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ABSTRACT

This textbook presents a conceptual and methodological framework for implementing quality assurance programs in mental health services, with specific emphasis on peer and utilization review. Both the content of the review and the methods of accomplishing it are addressed. The early chapters of the book are designed to show the many types and styles of evaluation criteria available, and to help readers determine what is appropriate for their facility. Mechanisms for measuring the quality of care and the process of concurrent and retrospective review are described. Different criteria formats and modes of criteria development are outlined, with specific attention paid to the concurrent review of partial hospitalization and ambulatory services. The implementation of a quality assurance program is then discussed. The quality assurance cycle is described and educational and organizational interventions are outlined. The focus of the book then shifts to the nature of organizations, to quality assurance activities within the framework of organizations with varying structures, and to the establishment of a functioning utilization and peer review system. Numerous figures supplementing the text, an annotated bibliography, an author index, and a subject index are included. (JAC)

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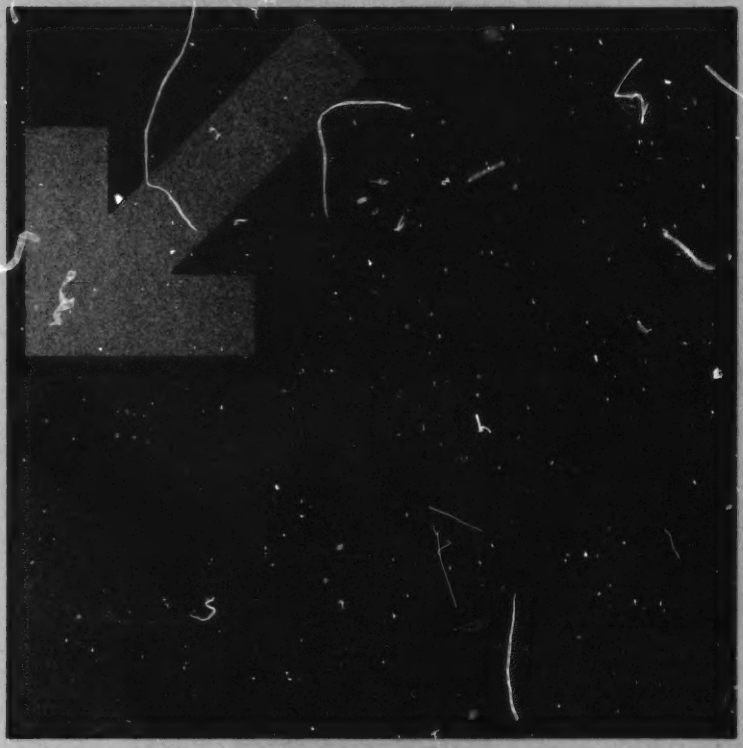
QUALITY ASSURANCE IN MENTAL HEALTH:

Peer and Utilization Review



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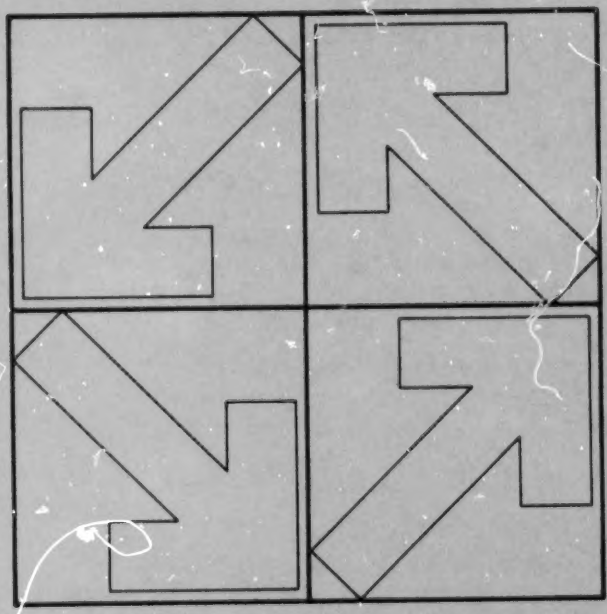

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FOREWORD

As the intramural educational component of the National Institute of Mental Health, The Staff College provides a multifaceted program of education and training activities to assist staff of NIMH and ADAMHA as well as others in State and local mental health programs around the country to maintain their effectiveness in the face of rapidly changing roles and responsibilities. These activities are developed in response to needs and in anticipation of changing priorities, with major emphasis on those subject areas most directly related to the improvement of mental health care.

Reflecting the diversity and flexibility that have characterized The Staff College program since its inception in 1974, program activities range from intensive courses, executive seminars, and advanced courses for trainers and consultants, to multiphased training programs, College Lectures, special meetings, and conferences. The publication of special materials has, additionally, been a high priority activity for The Staff College. As an outgrowth of courses and other training activities, these publications have enabled the College to extend its program beyond the classroom or meeting place.

The Staff College Publication Series in Program Management was initiated in 1977 to provide a framework for our materials development efforts. This new textbook, *Quality Assurance in Mental Health: Peer and Utilization Review*, is an addition to that series. We anticipate it will continue to be useful as a text for Staff College courses. But, equally important, it is designed for independent use by staff members in Federal, State, and local programs with varied responsibilities for assuring the quality of mental health care in both institutional and community settings. We additionally feel that the concepts, methodology, and organizational context presented in this volume may be equally applicable to quality assurance programs in other health care settings as well.

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PREFACE

As interest in the quality of mental health services has increased substantially in recent years, efforts to develop feasible and acceptable methods to assess and assure good quality care have intensified. But assuring the quality of mental health care has not been the exclusive province of mental health professionals. Government, third-party payers, and the general public have provided much of the impetus for these efforts and have become much more involved than ever before. This new textbook, *Quality Assurance in Mental Health: Peer and Utilization Review*, is part of that effort.

An outgrowth of The Staff College course on Assessing the Quality of Mental Health Services, the text presents a conceptual and methodological framework for implementing quality assurance programs. By providing a working knowledge of the major principles and practices of quality assurance, the book aims to assist mental health staff in a variety of settings—community mental health centers, State and local agencies and institutions, and Government—to improve the effectiveness and efficiency of their service programs. Its content and approach reflect the combined experience of the authors in teaching The Staff College course in many parts of the country, as well as their experience as mental health administrators, researchers, consultants, and pioneers in quality assessment in mental health.

It is important to note that the concept of accountability in the health field is not new. In fact, the concern for the quality of mental health services can be viewed from the perspective of events that took place within the medical sector. The roots of concern for the adequacy of medical care can be traced to the introduction of medical audits in general hospitals following World War I. These procedures became so well integrated into the medical system that they are now accepted practice within hospitals and institutions, along with requirements to earn accreditation and reimbursement.

The role of the Federal Government has been central to the evolution of quality assessment, mainly through legislative and administrative actions that date back to the early 1960s. Three actions are especially important: Initially, the Federal Government developed a review mechanism to monitor the private medical services provided to dependents covered by the Department of Defense

CHAMPUS program. Subsequently, Federal involvement in quality assurance was greatly expanded by a provision in the 1965 Social Security Amendments that required general hospitals and extended care facilities to implement utilization review committees. As a result, national standards for Medicaid and Medicare services were developed. Most recently, the Federal role was further expanded with the establishment under the 1972 Social Security Act of Professional Standards Review Organizations (PSROs) to serve as independent, external medical review bodies for Medicaid, Medicare, and the Maternal and Child Health Program.

During the 1960s and 1970s, issues of accountability increasingly affected the mental health sector as well. Following passage of the Community Mental Health Centers (CMHC) Act in 1963, the emphasis was on community-based alternatives to inpatient services and provision of services in the least restrictive setting. Paralleling this, demands for accountability became more vocal and were heard from all sides—from Government, professionals, boards, consumers, and ultimately from Congress itself. Program evaluation methodology became a serious concern for the National Institute of Mental Health and for the complex and multifaceted community mental health center programs that were developing all over the country with Federal support. Evaluation activities multiplied at an impressive rate even before they were specifically mandated for individual CMHCs in the 1975 Amendments to the CMHC Act. Significantly, as part of this focus on improving evaluation capability, the need to develop quality assessment systems within mental health, comparable to those already operating within the medical sector, became clear.

As the national mental health agency, NIMH took the lead in 1969 to develop the needed methodology. Thus, the first major research project to address the problems of quality assessment of psychiatric services was, with NIMH support, undertaken jointly by the Connecticut Mental Health Center and Yale University—the Psychiatric Utilization Review and Evaluation (PURE) Project.* By drawing on the established principles of quality assessment in the medical sector and the outcomes of their psychiatric utilization studies, PURE researchers formulated a systematic approach to quality assessment within psychiatric settings that could indeed assure administrators, Government, third-party payors, and the public, that

*A detailed report of this research project can be found in Riedel, D.C.; Tischler, G. L.; and Myers, J. K. *Patient Care Evaluation in Mental Health Programs.* Cambridge: Ballinger, 1974.

mental health services could meet key evaluation criteria—that they were necessary, of proper quality, and could be offered at reasonable cost within an appropriate setting for an appropriate length of time.

Though the Federal Government continued to encourage and support efforts to improve and refine quality assessment procedures in mental health settings, the next major impetus to the development of quality assessment systems came as a result of new provisions in the CMHC Amendments of 1975 that mandated evaluating the effectiveness of service programs, reviewing the quality of services, and establishing "an ongoing quality assurance program (including utilization and peer review systems)." As legislation gave new and special prominence to the concern for the quality of mental health services, important questions arose. How should CMHCs approach this new task? What was quality of service and how could it be measured? What was an acceptable quality assurance plan and what were the components of a quality assurance system? Not surprisingly, the complexity of the questions and the general lack of knowledge about this area resulted in a widespread expression of need for special training. In response, The Staff College developed the course, Assessing the Quality of Mental Health Services, that led to the publication of this textbook.

The course focused on the "state of the art," the technology of quality assessment—but with an additional critical component to enhance its applicability to a range of diversified mental health service settings. Since quality assurance systems depend upon working through the most delicate interpersonal, interdisciplinary, and intraorganizational relationships, a core component was incorporated into the course curriculum that dealt with the nature and structure of organizations and the impact of organizational structure on quality assessment practices and processes, staff roles and responsibilities, and the effectiveness of quality assurance activities. As a result, the methodology for developing and implementing quality assurance systems and processes was presented in the context of the organization within which these systems must function. This integration of methodology and organizational theory and practice is similarly reflected in the book.

As indicated earlier, *Quality Assurance in Mental Health: Peer and Utilization Review* is designed to teach basic concepts and methods. Though institutional and community mental health center programs are used to illustrate the methodology, it should be emphasized that the application of the approaches described in the book is not restricted to these settings. Settings may change; basic guidelines and methodology remain valid. Once learned, they can be

applied and extended to a whole range of mental health settings and programs—as mechanisms for program monitoring and improvement, as educational tools, and as mechanisms for improving the effective and efficient utilization of staff and fiscal resources.

Isabel Davidoff
Assistant Director
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National Institute of Mental Health

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INTRODUCTION

QUALITY ASSURANCE IN MENTAL HEALTH: An Overview

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INTRODUCTION

QUALITY ASSURANCE IN MENTAL HEALTH: An Overview

To the extent that each of us constantly weighs alternatives in order to decide whether a particular course of action is practical or impractical, good or bad, honest or dishonest, we are evaluative animals. Evaluations help us establish personal priorities, determine our goals, and identify acceptable means for achieving these goals. The realization that evaluative judgments can challenge the validity of cherished activities or limit our range of action, however, makes us more comfortable in the role of the evaluator than the evaluated. The discomfort of being evaluated is particularly acute when a profession is concerned.

Eliot Freidson (1970) identifies a profession as "an occupation which has assumed the dominant position in the division of labor, so that it gains control over the determination of the substance of its own work." Thus, professionals are likely to view themselves as self-directing. Any encroachment or threatened encroachment upon the freedom to define a domain of practice is experienced as a violation of entitlement. The reaction is visceral as professionals respond to what is perceived as an assault upon the trustworthiness, ethical behavior, and knowledge base which legitimize their unique occupational status.

When a call for evaluation arises from outside a profession, it invariably generates tension and meets with resistance. We have witnessed such responses during the past decade as health and human service professions have come under increased scrutiny and review. The possibility always exists that an acknowledged need to evaluate the activities of a profession will be transformed into an act of expedience—an exercise in form rather than substance. This, however, need not be. In this textbook, a guide to quality assurance activities in mental health is offered with a specific emphasis on peer and utilization review. The book attempts to address both the content of the review and the methods for accomplishing it, keeping constantly in mind both the overt and subtle barriers to true quality assurance.

Without minimizing the impact of outside events and pressures, the authors of this book hope that it will help demonstrate that quality assurance in mental health is here to stay for its own sake. Assuring such quality is important not merely because it has been mandated but because of its potential for contributing positively to planning and decisionmaking.

HISTORICAL PERSPECTIVE: HEALTH RIGHTS, CONSUMERISM, AND COST

Gerald Klerman (1974) advances the premise that the status of mental health services in this country is historically dependent upon the economic stability of the nation. He notes that "marked fluctuations exist in public attitudes and professional activities in mental health . . . periods of reform, innovation and optimism have been followed by phases of criticism, disillusionment, dissension, and retrenchment . . . these reforms in mental health have coincided with periods of progressive social change in the larger American society, whereas the phases of reactions, criticisms, and retrenchment have occurred with the aftermath of war or economic decline."

The recent expansion in social welfare and public health services closely followed the postwar prosperity of the 1950s. The Federal Community Mental Health Centers (CMHC) Program evolved during the mid-sixties at the high point of that period of reform and innovation. One of the major themes of the period was the belief that need, not personal circumstance or income, should determine the availability of health care—a belief that reflects the Aristotelean premise:

> *Health of mind and body is so fundamental to the good life that if a person has any right as a citizen, then he has an absolute moral right to such a measure of good health as society and society alone is able to provide.*

The view of health care as a basic human right is a concept of enormous subjective force. It was the motivating factor in Federal initiatives such as the Medicare and Medicaid programs.

Paralleling the health rights movement was a strong drive toward consumerism. In the health field, consumerism is a theme that has been played out primarily around the issue of citizen and community participation. The Economic Opportunity Act of 1964 called for programs to be "developed, conducted, and administered with the maximum feasible participation of the residents of the areas and members of the group served." The importance of citizen involvement was also stressed in the CMHC Program. Legislation incorporated, or at least hinted at, the tenet; funding sources underlined its importance, and regulations attempted, with varying degrees of success, to explicate the principle. Most recently, strong emphasis has been placed upon citizen involvement in the health-planning initiatives undertaken at the Federal level.

Another significant aspect of consumerism is the belief that the recipient of a service has the right to raise questions about the services provided. The burden of proving that the service matches its claims falls to the provider. To the extent that consumers may not have sufficient knowledge to verify or judge what they have been told, however, a third party often assumes the role of consumer advocate. In the health area, governmental involvement is seen as a method for protecting the interests of the consumer with government agencies playing the role of advocate through the use of their regulatory authority.

The decade between 1965 and 1975 also witnessed an increase in expenditures for health care from $38.9 billion to $118.5 billion a year. The portion of the gross national product spent for health rose from 5.9 percent in 1965 to 8.3 percent in 1975. Over half the population of this Nation is currently covered by some form of private or subsidized public health insurance. These programs commit a third party to reimburse the provider for the expense of covered services. Since third-party payments are substantial, their purchasing power can be used to effect change. Recent initiatives by both governmental and nongovernmental third parties that embody both cost containment and evaluation requirements reflect the leverage of these third parties.

TOWARDS A SYSTEM OF ACCOUNTABILITY

The confluence of the health rights movement, consumerism, and the escalating cost of health care have turned the delivery, organization, financing, and control of health care into a highly politicized issue. As a result, pressure has increased for the more rigorous ap-

plication of principles of internal accountability, and there is growing evidence that self-regulation, as currently practiced, must eventually give way to a more pluralistic system of accountability which includes both the consumer and the body politic. Within this broader context, utilization and peer review offer not only systematic approaches toward achieving professional accountability, but also mechanisms for involving service providers in establishing parameters to determine both the effective utilization of services and the quality of care provided.

Interest in assessing and monitoring service quality is not new. Questions related to the adequacy of medical care led to the introduction of the medical audit concept in general hospitals during the post-World War I era. By 1952, a medical audit was required by the Joint Commission on Accreditation of Hospitals (JCAH) for hospital certification. The Federal Government began to address questions of service quality in the mid-sixties with the passage of the Social Security amendments. Hospitals and skilled nursing homes participating in Medicare and Medicaid programs were required to have operational utilization review programs. A utilization review plan was considered sufficient if it required: review on a sample or other basis of admissions to the institution, the durations of stays therein, and the professional services (including drugs and biologicals furnished), with respect to the medical necessities of the services and for the purpose of promoting the most efficient use of available health facilities and services. Thus, statutory authority in the area of quality assurance has existed in this country for over a decade.

Analyses by the Senate Finance Committee, the General Accounting Office, and the Department of Health and Human Services' Audit Agency, however, concluded that the utilization review activities were generally of a token nature and ineffective in curbing the unnecessary use of institutional services. In the face of these findings, Congress enacted the Professional Standards Review Organization (PSRO) Program (Title 11 Part B of the Social Security Act of 1972). Under the program, a nationwide network of voluntary, nonprofit regionally based review organizations was established to determine whether services provided under the Medicare, Medicaid, and Maternal and Child Health programs were necessary, of proper quality, and delivered in the most appropriate setting for an appropriate length of time. Provision was made for a PSRO to delegate its review authority to a hospital review committee. Both the PSRO and the delegated facility were obligated to develop and use explicit criteria. Three major review techniques were required: concurrent review of individual cases, clinical care evaluation studies, and profile analysis. The review process of PSROs has been similar

to that described in the regulations drafted for provisions in P.L. 94-63, the CMHC Amendments of 1975, and subsequent legislation that relate to issues of quality assurance in CMHCs. First, the center was to establish a committee responsible for directing the quality assurance program. The committee was to be multidisciplinary and representative of all relevant disciplines and service units involved in the delivery of care. Although the committee would be encouraged to develop its own review procedures, it would each year complete at least two clinical care evaluation studies similar to those required by PSROs. Criteria and standards would be developed for the review process and findings of the reviews disseminated to the center staff and governing body as well as to other appropriate bodies and persons. Finally, a plan describing the program would be written and made available to staff, patients, governing bodies, and the public.

The draft CMHC regulations were not officially adopted. They were, however, reflected in the draft Program Guidelines for the Community Mental Health Centers Act (1979) that for a substantial period of time provided the field with program suggestions, clarifications, and amplifications of the intent of the law. As such, they assumed a quasi-official status in the eyes of health care professionals, CMHC staff, community groups, and government agencies. In practice, CMHCs have adopted their own internal procedures for review of the quality of their services. These procedures vary enormously from center to center, but generally have emphasized review of ambulatory care in an interdisciplinary context.

Even as this book goes to press, the external forces governing the nature of mental health care in this country seem to be shifting once again. Regardless of the outcome of these changes, it seems unlikely that health and mental health facilities and agencies will substantially lessen their concern for the quality of their services. On the contrary, as competition for existing resources increases, measures of accountability may well become even more critical in determining the scope and direction of mental health service programs.

Against this background, this textbook presents an approach to utilization and peer review consistent with the aims of the CMHC quality assurance effort, though clearly equally applicable to a broad range of community mental health programs.

MEASURING QUALITY: NORMS, CRITERIA, STANDARDS

Attempts to assay the quality of care are based on the assumption that good care is recognizable and worth striving to attain. Good

care can be characterized through a set of interrelated questions about clinical practice:

- Does the presenting problem justify admission to treatment?
- Is the level of care offered consistent with the severity of the presenting problem?
- Given the nature and severity of the presenting problem, what length of treatment should be anticipated?
- For a particular diagnosis or presenting problem, what are the critical diagnostic and therapeutic services required in order to maximize the probability of a favorable outcome?
- What problems might occur to complicate the course of treatment?
- What are the key indications of successful treatment?

These questions serve as a framework for evaluating the relationship between how care is actually provided and notions concerning how care *ought* to be provided. The evaluation itself is accomplished through the use of three measures of performance: norms, criteria, and standards.

Norms are numerical or statistical measures that reflect the actual practice of professionals. They are derived from aggregate data concerning the care provided to a large number of patients. *Criteria*, on the other hand, are developed by professionals relying on their clinical expertise and on the professional literature. They take the form of statements which provide a benchmark for judging the necessity, appropriateness, and adequacy of selected aspects of clinical care. When a norm or criterion is put forth in a manner that clearly specifies what is acceptable and what is unacceptable practice, it is referred to as a *standard*. Standards are professionally developed expressions of acceptable variations from a given norm or criterion. Thus a standard might require that 100 percent of all individuals hospitalized with a diagnosis of schizophrenia have an admissions physical examination. Lack of documentation of such examination would require case review.

Taken together, norms, criteria, and standards allow us to determine both the relationship between actual and expected practice and the extent to which actual practice reflects the best of current

knowledge and opinion. Determinations based on case-by-case studies of individuals while still in treatment comprise the *concurrent review* process. In contrast, *retrospective review* focuses on the care provided to a specific group of patients/clients—patients treated in a specific unit, sharing a particular diagnosis or subjected to a specific treatment intervention, for example—by studying the records of those who are no longer in treatment.

In order to continuously monitor their effectiveness, mental health care facilities need to either adapt already formulated criteria or develop their own based on (1) the types of treatment they provide, (2) the clients and/or problems they treat, and (3) regional norms. The early chapters in this textbook are designed to show the many types and styles available and help the reader determine what is appropriate for his facility. Mechanisms for measuring the quality of care and the process of concurrent and retrospective review are described. Different criteria formats and modes of criteria development are outlined, with specific attention paid to the application of a criterion-oriented approach to the concurrent review of partial hospitalization and ambulatory services.

Having considered the mechanisms of review, the textbook then discusses implementation of a quality assurance program. The quality assurance cycle is described, and educational and organizational interventions for assuring service quality are set forth. The focus of the book then shifts. Quality assurance programs exist within the organizational context and cannot be accomplished without an in-depth understanding of the full range of organizational issues. Emphasis is, therefore, given in this book to the nature of organizations, to quality assurance activities within the framework of organizations with varying structures, and to the establishment of a functioning utilization and peer review system.

REFERENCES

Freidson, E. *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd, Mead and Co., 1970.

Klerman, G. Current evaluation research on mental health services. *American Journal of Psychiatry,* 131:783-787, 1974.

CHAPTER ONE

CONCURRENT REVIEW: Process, Mechanisms, and Functions

Chapter One discusses the process of concurrent review, including admission certification and continued-stay review, the role of review coordinators, and the use of common criteria formats for determining the necessity for treatment or continued care.

KEY TOPICS

- The process of concurrent review
- Differential use of criteria categories:
  - diagnosis-specific criteria
  - generic criteria
  - problem-specific criteria
- Justifying admission to treatment
- Establishing length-of-stay norms
- Factors influencing an individual's length-of-stay
- Justifying the need for extending treatment
- The functions of the review coordinator and the clinician reviewer

CHAPTER ONE

CONCURRENT REVIEW: Process, Mechanisms, and Functions

Concurrent review involves two related mechanisms—*admission certification* and *continued-stay review*. The former is conducted at the time of admission to the program or facility to assure that treatment is necessary. Continued-stay review occurs during the course of treatment to assess the need for continued care.

HOW DOES CONCURRENT REVIEW WORK?

In the concurrent review process, norms, criteria, and standards are used to screen a large number of cases in order to identify exceptions to what is considered appropriate and adequate care. The initial screening is generally performed by a person designated as the *review coordinator*. The coordinator is responsible for the daily review of (1) all cases requiring either admission certification or recertification for continued treatment, (2) the documentation of certification and recertification decisions, and (3) the assignment of length-of-stay checkpoints. Nurse clinicians, record librarians, and specially trained paraprofessionals have all been used as review coordinators. The initial screening may be done by directly reviewing a patient's chart or by reviewing a specially prepared abstract which includes all required information.

Experience has shown in approximately one out of ten cases (Goran et al. 1975) that the review coordinator will question the rationale for an admission. The question may arise because alternative levels of care are available and may be appropriate, the diagnosis does not usually require the type of treatment prescribed, or the diagnosis has not been adequately established. When admission criteria are *not* met, the coordinator cannot take independent action but must refer the case to a clinician reviewer.

The clinician reviewer examines the chart and usually speaks to the patient's clinician. The reviewer may then decide that the case meets the criteria and approve the admission. For example, he may find that the information justifying admission has not been adequately noted in the patient's chart. Or he may decide that the specific circumstances related to the individual case are somewhat unusual and merit treatment at the level of care to which the patient was admitted. The clinician reviewer can also decide that the level of care assigned is not indicated or that the findings do not warrant treatment. If the admitting clinician disagrees, provision should be made for adjudication by a third person. This may be another clinician reviewer or a panel of peers.

For those patients whose admission is certified, a second review date is assigned for continued-stay review. The interval between the date of admission and the second review is based on length-of-stay norms developed regionally in regard to levels of care and specific diagnoses or problems.

The second review is performed by the review coordinator to determine whether indications for continued-stay exist. Once again, in the vast majority of cases, such indications will be documented, continued stay will be approved, and a new checkpoint for review assigned. When screening criteria justifying continued-stay are not met, the case is referred for clinician review. Once again, the clinician reviewer may find that indications for continued stay are present although not well documented, or that the case demonstrates unusual features that do not meet the ordinary criteria for continued stay but justify ongoing treatment or he may find no indication for continued stay. If continued-stay is approved, a new checkpoint will be established.

As can be seen, the primary function of a review coordinator is to determine whether care provided meets pre-established criteria governing the necessity and appropriateness of treatment. The review coordinator has only the power to make positive decisions—that is, to identify cases where the level of care is acceptable or where conditions for admission to treatment or extended duration of stay have been met. Cases which deviate from the pre-established

norms and criteria must be referred for peer review. One's clinical peers are the only people who can decide that adequate standards of practice have not been met.

JUSTIFYING ADMISSION TO TREATMENT

Decisions concerning the need for treatment and the level of care required are rarely made solely on the basis of mental status examinations. Other factors—the extent to which people represent a threat to themselves or others, their ability to care for themselves, the availability of social supports or treatment resources, and prior response to treatment, for example—must all be considered when a clinician attempts to justify the necessity of treatment and specify the level of care. Judgments about inpatient, partial hospitalization, or outpatient levels of care must be objectively described. For admission certification, three categories of criteria are commonly used: *diagnosis-specific*, *generic*, and *problem-specific*.

Diagnosis-specific criteria

The most common method for determining the need for treatment or continued care uses diagnosis-specific criteria developed in relation to a particular condition. This method requires two steps: (1) establishing that the specific condition exists through the use of criteria validating a particular diagnosis; and (2) specifying the circumstances that indicate the need for care through criteria justifying admission to treatment.

Data derived from the mental status examination are generally relied on to validate the diagnosis. *Screening criteria* attempt to use data that are easily documented and readily retrieved from the clinical record, with emphasis on the minimal information required to reasonably establish the diagnosis. An example is provided in figure 1.

Given the questions that exist about the reliability and validity of psychiatric diagnoses, some argue that greater rigor should characterize our effort at establishing a diagnosis. One possibility is to use specifically developed symptom scales such as the one illustrated in figure 2.

Alternatively, it is possible to use rigorous research criteria such as those developed by Feighner (1972) and his associates as the basis for validating diagnosis. These criteria cover a range of factors broader than just symptomatology, as the example in figure 3 suggests.

The use of scales or research diagnostic criteria requires a more systematic input of basic information than the screening criteria

FIGURE 1

Screening Criteria Validating the Diagnosis of Schizophrenia

Mental status examination documenting:

A. thought disorder (e.g., thinking that is bizarre, delusional, illogical, loose, blocked, autistic, markedly unrealistic, overly inclusive, or concrete);

AND

B. perceptual disorder (e.g., hallucination, illusion, depersonalization);

OR

C. affect disorder (affect that is ambivalent, inappropriate, blunt, or flat);

OR

D. disordered behavior (e.g., behavior that is withdrawn, regressive, bizarre, or inappropriate).

Source: *APA Manual of Psychiatric Peer Review.* American Psychiatric Association, Washington, D.C., 1976. Reprinted with permission.

FIGURE 2

Scale-Format for Validating the Diagnosis of Schizophrenia

THE NEW HAVEN SCHIZOPHRENIA INDEX

Symptoms

1. (a) Delusions (not specified or other than depressive).....
   (b) Hallucinations (auditory).....
   (c) Hallucinations (visual).....
   (d) Hallucinations (other).....

2. Crazy thinking and/or thought disorder

   Any of the following:

   (a) Bizarre thinking.....

   (b) Autism or grossly unrealistic private thoughts.....

   (c) Looseness of association, illogical thinking, overinclusion.....

   (d) Blocking.....

   (e) Concreteness.....

   (f) Derealization.....

   (g) Depersonalization.....

3. Inappropriate affect.....

4. Confusion.....

5. Paranoid ideation (self-referential thinking, suspiciousness).....

6. Catatonic behavior

   (a) Excitement.....

   (b) Stupor.....

   (c) Waxy flexibility.....

   (d) Negativism.....

   (e) Mutism.....

   (f) Echolalia.....

   (g) Stereotyped motor activity.....

Scoring System

To be considered part of the schizophrenic group, the patient *must* score on either item 1 or items 2a, 2b, 2c and must attain a total score of at least 4 points. He can achieve a maximum of 4 points on item 1: 2 for the presence of delusions, 2 for hallucinations.

On item 2—he can score 2 points for *any* of symptoms a through c, 1 point for either or both symptoms d through e, and 1 point each for f and g. He can thus score a maximum of 5 points on item 2.

Items 3, 4, 5, and 6 each receive 1 point.

Note: Where the 4th point necessary for inclusion in the sample is provided by 2d or 2e, these symptoms are not scored.

Source: Astrachan, B. M.; Adler, D.; Brauer, L.; Harrow, M.; Schwartz, A.; Schwartz, C.; and Tucker, G. A checklist for the diagnosis of schizophrenia. *British Journal of Psychiatry*, 121: 529-539, 1972. Reprinted with permission of the copyright holder. Copyright © The British Journal of Psychiatry, 1972.

FIGURE 3

Checklist Format for Validating the Diagnosis of Schizophrenia

History and mental status examination documenting:

A. *Both:*

1. a chronic illness with at least six months of symptoms prior to the index episode without return to the premorbid level of psychosocial adjustment;
2. absence of a period of depressive or manic symptoms sufficient to qualify for affective disorder or probable affective disorder.

B. At least *one* of the following:

1. delusions or hallucinations without significant perplexity or disorientation associated with them;
2. verbal production that makes communication difficult because of lack of logical or understandable organization. In the presence of muteness the diagnostic decision must be deferred.

C. At least *three* of the following must be present for a diagnosis of "definite" and *two* for a diagnosis of "probable" schizophrenia:

1. single;
2. premorbid social adjustment or work history poor;
3. family history of schizophrenia;
4. absence of alcoholism/drug abuse within 1 year of onset of psychosis;
5. onset of illness prior to age 40.

Source: Feighner, J. P.; Robins, E.; Guze, S. B.; Woodruff, R. A.; Winokur, G.; and Munoz, R. Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*, 26:57-63, 1972. Reprinted with permission of the copyright holder. Copyright © 1972-1976, American Medical Association.

displayed in figure 1. The documentation must, therefore, be more extensive and precise. However, the degree of rigor and precision imposed by these later methods may prove overly stringent, given the large number of cases to be screened, the primary focus on justifying the need for care, and the labor-intensive nature of the concurrent review process. Furthermore, criteria justifying admission to treatment such as these illustrated in figure 4 must still be met even after the diagnosis has been validated.

FIGURE 4

Diagnosis-Specific Criteria (Schizophrenia) Justifying Admission to Inpatient Care

A. Justification for Admission:

1. Potential danger to self, others, or property

OR

2. Impaired reality testing accompanied by disordered behavior

OR

3. Need for continuous skilled observation, ECT, high-dose medication, or therapeutic milieu

AND

4. Impaired social, familial, or occupational functioning.

B. Documentation/Validation

1. Destructive gesture or threat towards self, others, or property
2. Mental status examination indicating:

thought disorder **AND** perceptual disorder, **OR** disordered behavior, **OR** affect disorder.

3. Failure or unavailability of appropriate outpatient management (A 3, 4)

Source: *Model Screening Criteria to Assist PSRO's.* American Medical Association, Chicago, Illinois, May 1975. Reprinted with permission of the American Medical Association.

Generic criteria

Scrutinizing diagnosis-specific criteria for a number of disorders soon reveals a good deal of overlap in criteria justifying admission. These items include indicators of functional impairment, dangerousness, the need for special services, the ability to respond to treatment, and the availability of alternative treatment resources—factors hardly unique to a particular diagnosis.

Many clinicians believe that the need for treatment is governed more by these factors than diagnosis. They argue that validating the diagnosis merely adds an unnecessary step to the concurrent review process—particularly where hospital care is concerned—and recommend the use of nondiagnosis-specific level-of-care criteria as the sole method for justifying admission to treatment. Generic criteria of this nature have been developed for inpatient care and can be constructed either as scales (figure 5) or as checklists (figure 6).

Problem-specific criteria

Certain problems and behaviors confront clinicians with particularly difficult decisions about hospitalization as opposed to less costly or restrictive treatment alternatives. In such instances, problem-specific hospital level-of-care criteria can facilitate the determination. Their use should be limited to the most common problems where complex decisions concerning the appropriate level of care are likely to occur. Suicidal behavior is clearly such a problem. An example of problem-specific criteria justifying the involuntary hospitalization of a suicidal patient is presented in figure 7.

ESTABLISHING LENGTH-OF-STAY NORMS

Once a person is admitted to treatment, an initial checkpoint is established to indicate the number of days or treatment sessions authorized prior to continued-stay review. This assignment is based upon length-of-stay (LOS) norms developed for a particular

FIGURE 5

Scale for Justifying Admission to Inpatient Care

Instructions to reviewers: 1) Rate each patient on each criterion as: none = 0, slight = 1, moderate = 2, extensive = 3; multiply the rating by the weight shown and enter the score on each criterion. Then sum scores on each criterion for total

score. 2) Ratings are to be based on the patient's condition in the 7 days preceding evaluation for hospitalization. 3) In applying the criteria, an item of reported behavior should be employed to arrive at a rating on the first criterion on the list to which it applies. Do not use the same item of behavior to score a criterion that falls later in the list (e.g., suicidal behavior should not be used in rating criteria numbers 4 and 5).

	Weight	Score
1. Is there evidence of active suicidal preoccupation in fantasy or thoughts of patient?	2	____
2. Have there been suicidal attempts or active preparations to harm self (i.e., buying a gun, etc.)?	4	____
3. Has the patient threatened to hurt someone else physically? (Limit to verbal threats only.)	2	____
4. Have aggressive outbursts occurred toward people?	4	____
5. Have aggressive outbursts occurred toward animals or objects?	2	____
6. Has antisocial behavior occurred?	1	____
7. Are there evidences of impairment of such functions as reality assessment, judgment, logical thinking, and planning?	1	____
8. Does the patient's condition seem to be deteriorating rapidly or failing to improve despite supportive measures?	1	____
9. Are there physical or neurological conditions or a psychotic, disorganized state which require(s) hospitalization to initiate the treatment process?	2	____
10. Does a pathological or noxious situation exist among patient's family or associates that makes initiation of treatment without hospitalization impossible? OR does the patient's disordered state create such difficulties for family or associates that he has to be removed and hospitalized for their sake?	1	____
11. Are emotional contacts of the patient so severely limited or the habitual patterns of behavior so pathologically ingrained that the "push" of a structured hospital program may be helpful? (This criterion should not be applied to acute patients, but only to those who are so limited as to be unable to establish and maintain emotional contacts.)	1	____
12. Does evaluation of the patient's condition require the 24-hour observation and special evaluation that a hospital provides? (Including stabilization or reevaluation of medication.)	4	____

Source: Flynn, H. and Heniaz, J. Criteria for psychiatric hospitalization: Experience with a check list for chart review. *American Journal of Psychiatry*, 132(8): 847-850. August 1975. Reprinted with permission of the copyright holder. Copyright © The American Psychiatric Association, 1975.

FIGURE 6

Checklist Using Generic Criteria for Justifying Admission

A. General (at least one required)

1. Suicidal preoccupation or attempt
2. Threatened or actual physical violence
3. Impaired reality testing accompanied by disordered behavior with disruption in social, familial, and occupational functioning
4. Incapacitating and/or life threatening physical illness, but psychological components cannot optimally be handled on other services
5. Behavior intolerable to client, family, or community
6. Deleterious psychosocial interactions harmful to the patient
7. Failure of outpatient management or partial hospitalization

AND

B. Procedural (at least one required)

1. Absence of alternative resources in the community
2. Need for clarification of diagnosis by 24-hour behavioral observation
3. Need to evaluate any change in the patient's condition (unstabilized) that might necessitate modification of treatment procedures
4. Need for specialized treatment under 24-hour supervision, e.g., ECT, lithium, high-dose drug therapy, detoxification, or therapeutic milieu

FIGURE 7

Problem-Specific Criteria Justifying the Involuntary Hospitalization of Suicidal Patients

Indications for Admission

A. Current, clear suicide attempt
B. A clear, lethal suicide plan
C. A recent history of medically serious attempts
D. Suicidal thoughts, gestures, or attempts in association with delirium or psychosis
E. Recent marked progression in seriousness of thought or from thought to gestures
F. Expression of strong suicidal thoughts with intent without seeing another way out
G. An expectation of hospitalization that cannot be changed at interview
H. Expectations of change in significant others due to suicidal behavior are not met nor can be changed appropriately
I. Precipitating factor cannot be changed
J. High-risk social circumstances

diagnosis or problem. For example, in a given year 400 patients with a diagnosis of acute schizophrenic reaction are admitted to inpatient facilities in a given region. One-half of all patients are discharged by the 14th day. Since length of stay is generally expressed as a percentile, the 14th hospital day is the 50th percentile. Three-quarters of the patients are discharged by the 21st day. Thus the 75th percentile of length of stay is the 21st day of hospital-level care. Similarly, in this example, the 30th day represents the 90th percentile. In other words, only one of every ten patients required hospital-level care for more than 30 days.

Most concurrent review systems use the 50th percentile as the LOS norm or initial checkpoint. If a patient's stay is longer than that of half the patients in the same region with a similar problem or diagnosis, it becomes necessary to clinically justify continued care.

While deceptively easy to develop, LOS norms should be interpreted with some caution. Marked regional differences can exist in

measures such as average number of inpatient or partial hospitalization days or the mean number of outpatient visits/1000 catchment residents.

Figures 8A and 8B are based upon aggregated data collected from federally funded community mental health centers in 1973. At this level of aggregation, differences among regions could reflect a host of factors, including the availability of alternative treatment resources, the help-seeking behaviors of people in a particular area, or the clinical philosophy of those responsible for providing care. Given these discrepancies, it seems wise to rely on regional rather than national data in establishing LOS norms.

Even within a given region, however, LOS can vary from facility to facility. For example, figure 9 displays the relationship between

FIGURE 8A

Regional Differences in CMHCs in Length-of-Stay: By Modality

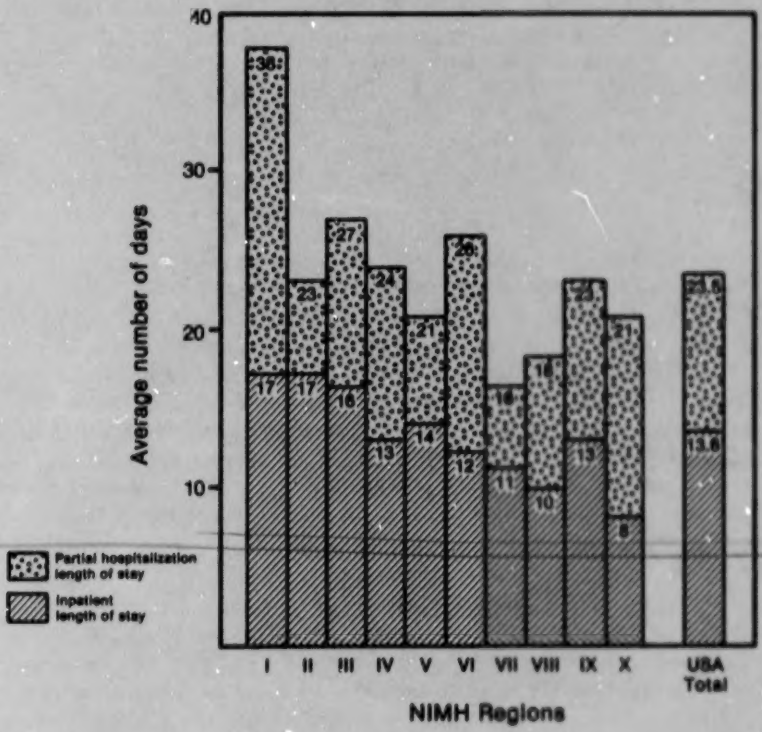


FIGURE 6B

Regional Differences in CMHCs: Outpatient Visits

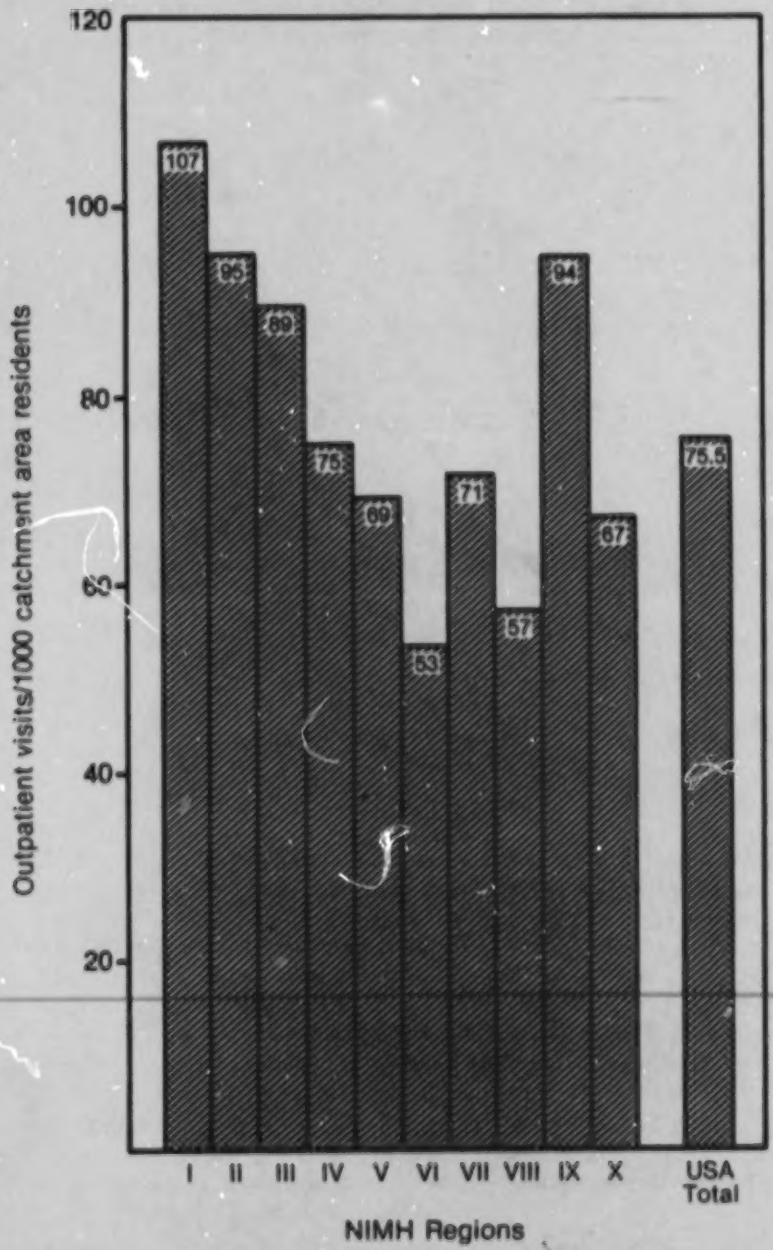
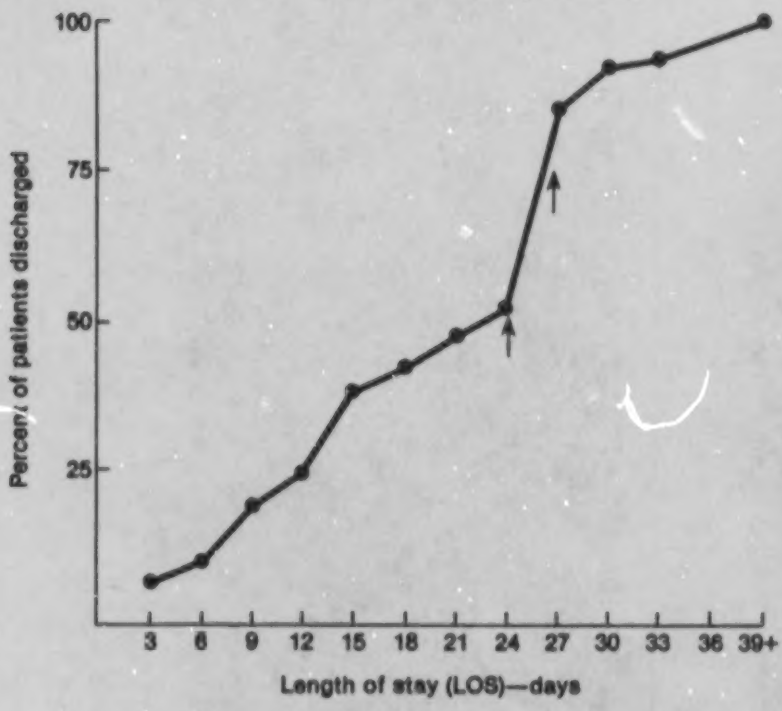


FIGURE 9

Area Inpatient Length-of-Stay for Patients with Schizophrenic Diagnosis (3 Facilities)



the number of hospital days and the percentage of patients discharged in a specific area with the same diagnosis—schizophrenic reaction.

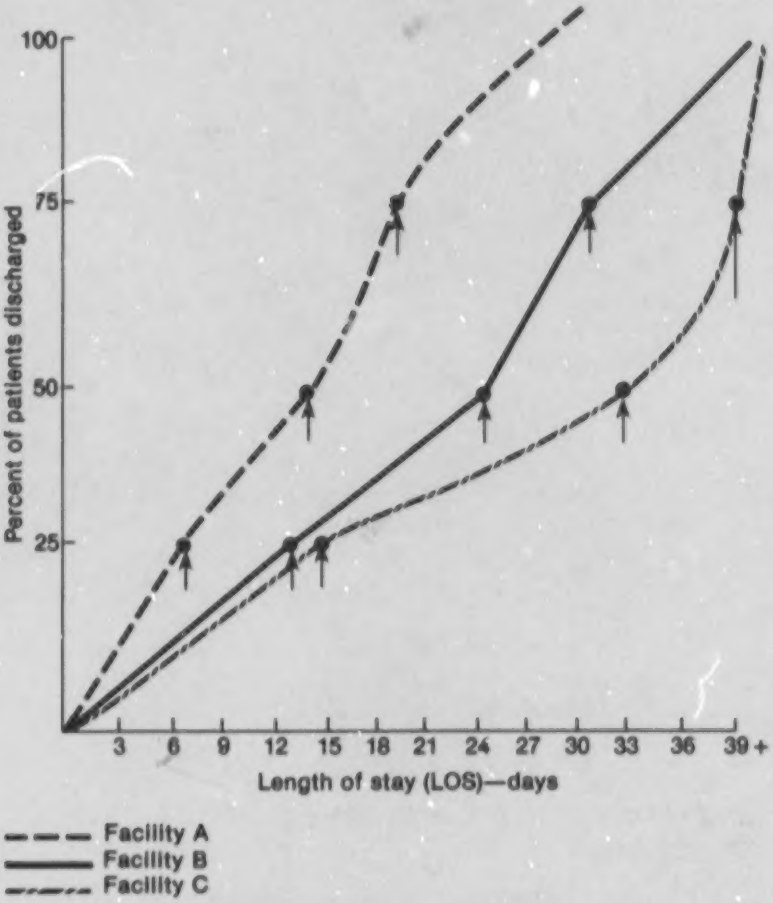
When the individual facilities are compared, as in figure 10, we find considerable variation at both the 50th and 75th percentiles.

Even within the single facility, LOS norms for a given diagnosis can vary. Figure 11 subdivides the patient population by age (<21 and 21 +). While the 50th percentile is similar, a 6-day difference exists at the 75th percentile.

All this is by way of saying that factors such as administrative policy, age, income, and availability of family supports can all influence the application of an LOS norm. For that reason, it is impor-

FIGURE 10

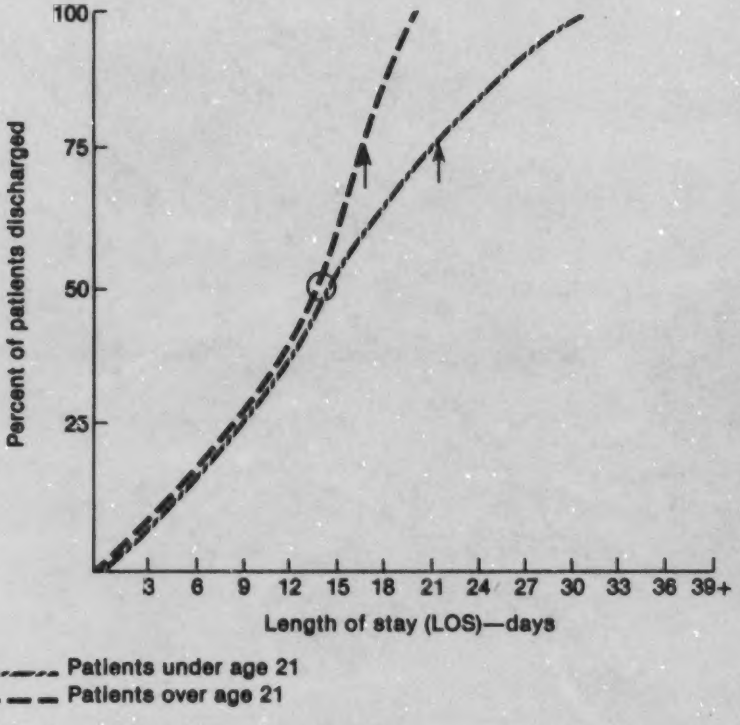
Facility Inpatient Length-of-Stay for Patients with Schizophrenic Diagnosis



tant to regard the norm as nothing more than a general guideline. A person's readiness for discharge or transfer to a different level of care should not be reduced to a simple equation. Judgments concerning the need for continued care must also take into account the patient's clinical status and response to treatment.

FIGURE 11

LOS for Patients with Schizophrenic Diagnosis: Facility A



JUSTIFYING THE NECESSITY FOR EXTENDING TREATMENT

The need for continued care is dictated by issues related to the clinical status of the patient, the availability of social supports, and the existence of appropriate follow-up services. Each of these factors must be taken into account in justifying the need for extending treatment. Thus it is important to know something about a patient's current status, the course of treatment, and the anticipated outcome when treatment was undertaken. This information forms the basis for determining whether the circumstances originally justifying admission to treatment still exist, whether the course of treat-

ment was confounded by complications or by problems in implementing a treatment program, whether certain services that can be provided only at the specific level of care are still required, or whether adequate progress has been made in relation to the original treatment objectives. The criteria used may be either diagnosis-specific or generic (see figures 12 and 13).

FIGURE 12

Diagnosis-Specific Criteria for Justifying Extended LOS

Drug Abuse/Drug Dependence
Adult or Adolescent
DSM-11 304
ICDA-8 304
HICDA 314

I. ADMISSION REVIEW

A. *Reasons for Admission*

1. Potential danger to self, others, or property, *or*
2. Excessive use of drugs or other chemical substances, and
3. Planned detoxification/withdrawal, *or*
4. Need for continuous skilled observation, controlled chemotherapy, or therapeutic milieu
5. Legally mandated admission

B. *Initial Length of Stay Assignment*

Locally established based on statistical norms

II. CONTINUED STAY REVIEW

A. *Reasons for Extending the Initial Length of Stay*

1. Continued danger to self, others, or property
2. Continued need for detoxification/withdrawal or therapeutic milieu
3. Complication of medication

III. VALIDATION OF

A. *Diagnosis*

1. Documentation of drug or chemical use great enough to damage physical health, or personal or social functioning, or as a prerequisite to normal social functioning, *or*

2. Documentation of impaired social, familial, or occupational functioning, *and*
3. Qualitative toxicological studies positive for nonprescribed drugs or chemicals, *or*
4. Quantitative toxicological studies showing prescribed drugs in higher than therapeutic levels

B. *Reasons for Admission*

1. Documented danger to self, others, or property (I-A1)
2. Documentation of drugs/chemical abuse pattern noted above (directly or with supporting toxicological evidence) (I-A2)
3. Documentation of current drug/chemical toxication/addiction (I-A3)
4. Documentation of failure or unavailability of appropriate outpatient management (I-A4)

IV. CRITICAL DIAGNOSTIC AND THERAPEUTIC SERVICES

A. Toxicology screen (blood or urine) 100%

B. Treatment plan to include problem formulation, treatment goals, and therapeutic modalities (e.g., psychotherapy, pharmacotherapy, social therapies, behavior modification) 100%

C. More than two psychotropic medications at any given time 0%

D. Change of psychotropic medication more than twice in a seven-day period 0%

E. ECT 0%

V. DISCHARGE STATUS

A. Achievement of inpatient treatment goals (as outlined under IV-B)

B. Specific follow-up treatment plan established

VI. COMPLICATIONS

A. *Primary Disease and Treatment—Specific Complications*

1. Withdrawal seizures
2. Complication of medication
3. Continued drug/chemical abuse during hospitalization

B. *Nonspecific Indicators*

1. Suicide or attempt
2. Development/peristence of psychosis after the 14th hospital day
3. Elopement or discharge against medical advice
4. IM psychotropic medication for more than ten days
5. Readmission within 30 days of discharge

Source: *Manual of Psychiatric Peer Review*, American Psychiatric Association, Washington, D.C., 1976. Reprinted with permission.

FIGURE 13

Generic Criteria for Extending Initial LOS

A. General (at least one required)

1. Persistence of disabling symptoms
2. Concomitant physical illness
3. Adverse reaction to medication, ECT
4. Major unanticipated life stress during hospitalization
5. Family or socioeconomic factors of sufficient severity to immediately cause decompensation if patient is discharged
6. Hospital treatment career demonstrated lack of readiness for discharge, e.g., elopement, suicide gesture
7. Historical evidence that previous short stay was inadequate
8. Initial treatment goals not fully realized

AND

B. Procedural (at least one required)

1. Planning for alternate care not complete
   a. Awaiting transfer to dependent care facility or other facility
   b. Awaiting economic support arrangements
2. Lack of facilities for appropriate continuing care
3. Discharge difficulties related to family and/or community rejection
4. Initial treatment plan was changed or modified

REFERENCES

American Medical Association. *Model Screening Criteria to Assist PSRO's.* Chicago: The Association, 1975.

American Psychiatric Association. Peer Review Committee. *Manual of Psychiatric Peer Review.* Washington, D.C.: The Association, 1976.

Astrachan, B. M.; Adler, D.; Brauer, L.; Harrow, M.; Schwartz, A.; Schwartz, C.; and Tucker, G. A checklist for the diagnosis of schizophrenia. *British Journal of Psychiatry,* 121:529-539, 1972.

Feighner, J. P.; Robins, E.; Guze, S. B.; Woodruff, R. A.; Winokur, G.; and Munoz, R. Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry,* 26:57-63, 1972.

Flynn, H., and Henisz, J. Criteria for psychiatric hospitalization: Experience with a check list for chart review. *American Journal of Psychiatry*, 132(8): 847-850, 1975.

Goran, M. J.; Roberts, J. S.; Kellogg, M. A.; Fielding, J.; and Jessee, W. The PSRO hospital review system. *Medical Care*, 8(4) Supplement: 1-33, 1975.

Whittington, H. G. *Psychiatry in the American Community*. New York: International University Press, 1966.

CHAPTER TWO

CONCURRENT REVIEW: Level-of-Care

Chapter Two presents the application of a criterion-oriented approach to the concurrent review of different levels of patient care, including inpatient care, partial hospitalization, and ambulatory care. Three types of day treatment programs with differing goals are discussed as appropriate alternatives to full hospitalization.

KEY TOPICS

- Concurrent Review Procedures of Inpatient Care
- Concurrent Review of Partial Hospitalization Treatment
- Goal-Oriented Functions of Day Hospitals and Services
- Concurrent Review of Ambulatory Care Services

CHAPTER TWO

CONCURRENT REVIEW: Level-of-Care

Methods must be adopted to evaluate the appropriateness of level-of-care within a facility. A disservice is done to both patients and staff if patients are misassigned or retained too long at a particular treatment level. Ideally, concurrent admission certification and continued-stay review would be routine for every case. Since these are, however, the most labor-intensive of all review mechanisms, the volume of care provided by a particular institution as well as staffing patterns may make it impractical to review all instances of treatment.

Level-of-care review is further complicated by the qualitative differences in diagnosis and expectations associated with the three major treatment levels: inpatient, partial hospitalization, and ambulatory. One set of criteria cannot be applied across the board to determine patient placement or release. Thus the review for each of these levels must be discussed separately.

CONCURRENT REVIEW OF INPATIENT CARE

Because of the relative costliness of inpatient care, hospital-level treatment generally receives the greatest attention. All elective inpatient admissions should initially be certified unless there is clear evidence: (1) that a specific diagnosis or a particular clinician does

not need such review, or (2) that available manpower is inadequate to handle the volume generated by a 100-percent review. Certification of emergency admissions to hospitals should be required either for all emergency admissions or for a sample of admissions that covers all clinicians and all major diagnoses within a reasonable period of time.

As experience is garnered in concurrent review, however, it is possible to use the results of retrospective review efforts to identify areas where admission certification or continued-stay review should be intensified or lessened. For example, routine reviews could be discontinued when data demonstrate (1) the absence of admission denials for a particular clinician or condition, (2) excellent compliance over a period of time with length-of-stay norms for a particular clinician or condition, or (3) consistently excellent client outcomes for a given condition. On the other hand, a study of the data may indicate that specific conditions or clinicians are especially in need of close surveillance. These cases can be given particular attention in the review process.

In other words, once diagnosis-specific and hospital level-of-care criteria and standards have been developed and evidence concerning admission and utilization practices is available, it becomes possible to identify classes of admissions that can be automatically certified or, conversely, that require close review and/or preadmission certification.

CONCURRENT REVIEW OF PARTIAL HOSPITALIZATION

The procedures designed for review of inpatient care can be modified and applied to the concurrent review of partial hospitalization treatment. A number of different types of day hospitals exist, so the development of review criteria must also take into account the major goals of the treatment facility. Day hospitals generally serve one of three functions: (1) to be an alternative to inpatient care; (2) to facilitate re-entry to the community; or (3) to be a rehabilitative setting for the chronically ill.

Those day hospitals which serve as alternatives to full-time hospitalization seek to intervene with patients who would otherwise require hospital-level treatment. Thus, criteria for admission would be similar to those used for inpatients. These criteria can be formulated on the basis of specific diagnoses, but they will invariably have to address generic issues such as the individual's functional capacity and the availability of social and familial support. In general, as shown in figure 14, it should be possible to modify

FIGURE 14

Admissions Criteria for Day Hospital Used as an Alternative to Full-Time Hospitalization

Justification for Admission

A. Evidence that patient requires hospitalization based on either diagnosis-specific or generic admissions criteria for hospital-level care (for example, see figures 4-7).

B. Day hospital is an appropriate alternative to full hospitalization when

1. No major physical contraindications exist

AND

2. Patient is not dangerous to self or others

AND

3. Adequate environmental resources are available to monitor and support evening and weekend activities.

hospital-level criteria for this type of day hospital setting. Continued-stay criteria can also be modified from inpatient-level criteria such as those illustrated in figures 12 and 13.

In those day hospitals which serve to facilitate the re-entry of patients into the community, generic criteria will be most useful (see figure 15A). That is, to justify moving from inpatient care to a day hospital setting, the patient must demonstrate symptom improvement and enhanced functional capacity. The availability of family or other community resources to receive the patient is also important. Criteria may also be included that relate to the patient's ability to respond to specific therapeutic interventions such as socialization or prevocational training.

Since the primary function of the day treatment setting is to provide transition, continued-stay review is particularly important to establish readiness for transfer to a still less restrictive treatment setting. Generic criteria such as those shown in figure 15B provide perhaps the best way of approaching the task.

Admission certification for day hospitals concerned with rehabilitation should be based upon some mix of generic, problem-oriented, and diagnostic criteria. The day hospital has been described as an

FIGURE 15A.

Admissions Criteria for Day Hospital Used to Facilitate Reentry into the Community

Justification for Admission

A. The patient has improved during inpatient treatment but discharge to ambulatory care is not yet possible

BECAUSE

B. Psychological functioning is still too tenuous
(e.g., patient has symptoms of serious depression, continued withdrawal, psychomotor retardation, or serious symptoms of thought disorder) and patient requires a structured treatment setting.

OR

C. Medication regime has not been stabilized
(e.g., medications appropriate to diagnostic condition are prescribed and have not successfully modified symptoms. Medication has been begun, but because of possible toxicity and/or problems with compliance, it must be given in a supervised setting.)

OR

D. Discharge planning is not complete or adequate alternative structured living arrangement is not available.

FIGURE 15B.

Continued-Stay Criteria for Day Hospital used to Facilitate Reentry into the Community

Justification for continued stay

A. Treatment objectives have not yet been achieved
(patient remains seriously symptomatic and unable to function in a less structured setting)

OR

B. Medication regime is not stabilized

OR

C. Complications have occurred
(e.g., drug side effects, serious environmental stress, intercurrent illness requiring diagnostic evaluation and treatment.)

OR

D. Discharge planning is not yet complete
(adequate community alternatives are not available or not yet in place.)

excellent treatment setting for borderline patients, who may require intensive psychological and social rehabilitation but can seriously regress within an inpatient setting. Day hospital treatment programs require patients to return home nights and weekends and preserve functional capacity. Patients with a specific diagnostic label (borderline) or with a particular problem (excessive dependency needs) may thus be treated with social psychological therapies in order to both limit regression and increase functional capacity. Indeed, in return for maintaining their functioning, the patients may have some limited dependency needs gratified within the day hospital. In addition, day hospitals serving rehabilitative ends frequently request the collaboration of family or other significant figures in the patient's life, and criteria should reflect this (figure 16).

In this type of day hospital, continued-stay review is related to the individual's general level of functioning and capacity to participate in and benefit from specific therapeutic programs. The criteria should be constructed in such a way as to assess functional capacity. For example, prevocational assessment may help identify an individual's capacity to benefit from specific rehabilitative services. Continued stay might be related to completion of an evaluation process, participation in an ongoing rehabilitative program, and the availability of community resources.

FIGURE 16

Admissions Criteria for Day Hospitals Used for Rehabilitation

Justification for Admission

A. The patient has a diagnosable and major psychological disorder (e.g., see figures 2, 3, and 12) or is seriously symptomatic (e.g., see figures 5 and 6).

B. The patient is seriously debilitated and functionally limited

AND

C. Evaluation of the patient's psychosocial function has identified defects in social functioning, work performance, and/or family role for which rehabilitative therapies which require a structured environment are available.

CONCURRENT REVIEW OF AMBULATORY CARE

Problems in review become increasingly complex as one moves to the ambulatory-care area where the volume of service may be extraordinarily high, duration of treatment relatively brief, and recordkeeping usually poor. A number of ambulatory-care review models have been developed. Almost all assume that admission certification will automatically occur without prior authorization. Since a large number of individuals drop out of ambulatory treatment after one or two visits, duration-of-treatment review may be routinely scheduled for all who remain in therapy for the median number of visits identified as the norm within the particular geographical region.

The emphasis on continued-stay review rather than admission certification is reasonable both in terms of restraining costs and effectively utilizing services. Facilitating entry into ambulatory care may provide early intervention and prevent more restrictive and more costly forms of treatment. Additionally, the cost of reviewing an enormous number of cases of limited duration might well be prohibitive. Continued-stay review will place limits on the amount of treatment received, and, as with concurrent inpatient care review, will monitor the utilization of resources and restrain costs.

At the Peninsula Mental Health Center, a private-practice-oriented CMHC, all ambulatory treatment is reviewed after six visits. Continued treatment must be justified to a committee of peers in a setting analogous to a clinical case conference. The criteria are implicit. The review process emphasizes time-limited treatment, with clear identification of treatment goals and the manner in which treatment is expected to accomplish change. Published reports (Luft, Sampson, and Newman 1976; Luft and Newman 1977) indicate that approximately two-thirds of cases presented for review are approved. In about one-third of cases, modifications in the treatment plan are advised. These primarily emphasize reducing the duration of treatment. This review process has helped the CMHC hold down costs.

Several ambulatory review models are closely tied to psychiatric diagnosis. The *Manual of Psychiatric Peer Review** contains guidelines for reviewing ambulatory care activities. CHAMPUS and the American Psychiatric Association have also collaborated on

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*Prepared by the Peer Review Committee of the American Psychiatric Association in cooperation with the Joint Task Force on Diagnostic Criteria for Analyzability of the American Psychoanalytic Association and the Peer Review Committee of the American Academy of Child Psychiatry.

developing such criteria. In both cases it is assumed that admission certification will be routine. The primary review occurs when the median length of stay in treatment for a specific diagnostic group is reached. Criteria for review are explicit.

Karasu and his colleagues (1977) developed a review system for psychotherapy which is rooted in a psychodynamic theoretical base. They first establish diagnosis and then review care in relationship to four problem areas: (1) manifest symptoms and psychological problems; (2) characterological problems; (3) family and social relations problems; and (4) school, work, productivity, and creativity problems.

In each of these areas, problems are specified and rated on degree of severity. Clinicians must present behavioral evidence for the severity of problems, develop a psychodynamic formulation, and design therapeutic interventions built around desired outcomes. The authors do not, however, develop any criteria for admission certification, nor do they present any guidelines for continued-stay review. One might assume that duration of treatment within this framework would be related to regional norms.

All of these approaches use criteria based upon a clinical diagnosis. To our knowledge, no one has yet developed a comprehensive approach to defining explicit normative criteria for special problems. For example, determining criteria related to the problem of child abuse might benefit from such an approach (see figure 17). This figure presents a number of criteria for the treatment of child-abusing parents and shows how the criteria could be transformed into a checklist. The checklist incorporates the criteria in a manner that facilitates abstracting data from the clinical record, thus easing the review and audit process. The example provides a sense of the logic involved in transforming the criteria into a form more suitable for chart review.

Other problem-specific criteria could be developed in a similar manner. For example, areas of functional impairment could be identified and appropriate treatment strategies prescribed. Problems with important family members might be approached through various psychological therapies including individual, family, or group treatment. Problems at work might be addressed by vocational testing and rehabilitation and by assessing the individual's ability to socialize and his job requirements for socialization. Once again, admission certification might be relatively automatic, and continued-treatment criteria could be related to problem definition and progress in treatment.

In sum, for most ambulatory care, admissions certification will be automatic. Specialized treatment processes (e.g., psychoanalysis or

FIGURE 17

A Checklist Incorporating Criteria for the Ambulatory Treatment of Child-Abusing Parents

Criteria	Checklist Items
The initial checklist item identifies the problem being considered.	Was client(s) referred because of a history of abusing a child?
The next group of items spells out the information needed to determine if criteria for the individual treatment of an abusing parent have been met.	If **YES,**
The criteria are:	
1. The existence of a demonstrable clinical disorder	Is there evidence that the client(s) has a clinical condition (e.g., alcoholism, depression) which can be expected to improve with ambulatory care (use of appropriate diagnostic criteria or generalized level of care criteria) and that this condition directly accounts for the abuse?
WHERE	
2. The extent of abuse is relatively limited	Does the record indicate that abuse is relatively infrequent? Is abuse limited to a specific child rather than generalized to several children and/ or marital partner?
WHEN	
3a. Provisions have been made to ensure that the abused child is protected	Does the record provide evidence for ongoing liaison with requisite legal agencies to protect the abused child? Has the child received appropriate medical and psychological evaluation and treatment, if indicated? If indicated, has foster placement been accomplished?
AND	
3b. Adequate social supports are available to the family	Does the record indicate that social welfare agencies and/or extended family have been involved in providing support?
AND	
3c. Specific guidelines are established for interagency interaction	Does the record indicate where responsibility for treatment lies? responsibility for protection of the child? Is the record clear about which responsibility has priority, and when? Is confidentiality absolute? If not, does the record indicate that limits on confidentiality have been made clear to parent(s)?

various long-term rehabilitative treatments) may require admissions certification which demonstrate that the treatment modality is appropriate and necessary. Criteria for continued-stay review will reflect adequate problem formulation, therapeutic goals, and anticipated outcomes. They will also cover persistence of serious symptomatology and functional limitations, as well as the need for continued use of medical supervision and/or psychotropic agents. In addition, treatment could be extended because of complications such as more severe symptoms, problems with medications, intercurrent illness, or suicidal behavior.

In a quality assurance program for ambulatory care, it is important to develop and utilize criteria which both qualify services for reimbursement and reflect the work and the values of the treatment facility. Most of the models for review are derived from medical-psychiatric approaches. Although little work has been done to develop *explicit* criteria for the review of other approaches to mental health care, we have attempted to indicate that other strategies are possible.

REFERENCES

Karasu, T. B.; Stein, S. P.; Karas, F. I.; Buckley, P. J.; and Charles, E. S. "A Model Peer Review System for Psychotherapy." Mimeo draft, Albert Einstein College of Medicine. Presented at American Psychiatric Association, Toronto, Canada, 1977.

Luft, L. L., and Newman, D. E. Therapists' acceptance of peer review in a community mental health center. *Hospital & Community Psychiatry*, 28:889-894, 1977.

Luft, L. L.; Sampson, L. M.; and Newman, D. E. Effects of peer review on outpatient psychotherapy: Therapist and patient follow-up survey. *American Journal of Psychiatry*, 133:891-895, 1976.

CHAPTER THREE

CRITERIA: Development and Application

Chapter Three emphasizes the importance of criteria development and the implications of criteria for the manner in which adequate care is defined. It describes the differences between normative and empirical, explicit and implicit criteria, and the limitations of each. Finally, "peer review" is described as a process to assure quality of service, monitor appropriate utilization, and restrain cost.

KEY TOPICS

- The formulation of normative and empirical criteria and the limitations of each
- The development of implicit and explicit criteria as approaches to analyzing the quality of care
- The need to evaluate the utility and validity of criteria
- Group standards
- The process of peer review
- Goal attainment scaling
- The role of the review coordinator

CHAPTER THREE

CRITERIA: Development and Application

NORMATIVE VS. EMPIRICAL

According to Donabedian's usage (1966), criteria may be either *normative*—derived from the opinion of professionals—or *empirical*—based upon the actual practice of professionals. In either instance, criteria reflect the consensus of clinicians on the state of the art at a given time.

Normative criteria are formulated on the basis of professional opinion or, more rarely, clearly validated scientific information around an ideal of what represents excellence in clinical practice. A number of methods have been used to develop such criteria. These include the judgment of highly qualified practitioners, careful review of textbooks and standard publications, development of expert panels, and polls of practitioners. Since such opinions, notions, and pronouncements are likely to derive more from a body of legitimate knowledge and values than from actual practice, their validity depends upon the extent of agreement concerning data and values within a particular profession. For example, in a study of views about prescribing antibiotics for childhood respiratory infections (Wagner et al. 1976), general practitioners tended to see more indications for their use than did pediatricians. Pediatric specialists

in infectious diseases required the most intensive evaluation before prescribing them. As a result, questions have arisen about the relevance of normative standards developed by one group to the practice of another. Dissatisfaction has further been expressed about applying to clinical settings standards or criteria developed in academic centers. In a similar manner, the development and use of the *Diagnostic and Statistical Manual III (DSM III)* (American Psychiatric Association 1980) by American psychiatrists has led to some problems. The DSM III clearly specifies criteria for establishing diagnosis and is generally applauded for its aims and its scope. However, psychiatrists in other nations note that some of the terms in the volume have different meanings in their nations and, further, that some clinical conditions identified as of importance in their nations are not categorized in the volume. Some members of other professional groups identify the use of this diagnostic scheme as casting their work within a medical context and bemoan the absence of an accepted nosologic system that might more appropriately capture the essence of their work.

Empirical criteria are formulated from statistical analysis of actual patterns of care. They can be used to compare care in one setting with that in another or with statistical averages obtained from a number of similar settings. Since such criteria reflect demonstrable levels of care, they are likely to be more creditable and acceptable to practitioners at large and less subject to criticism as idealized constructs. There is, however, one major limitation to the use of empirical standards. Although the care-giving process may appear to be adequate compared to other situations, it can still fall short of what is attainable through the full application of current knowledge. Thus, it seems advisable to have empirical observations serve as criteria only if a normative element of judgment is added. Ideally, both normative and empirical sources should be drawn on in evolving standards of care.

Theoretical position as a factor

Criteria based upon diagnoses envision emotional and mental distress within a medical-psychological framework. Criteria for entry into psychoanalysis (admission certification) use the language and concepts of that theory to assess appropriateness for treatment (American Psychiatric Association 1976). Thus, psychoanalysis is indicated for patients in each DSM category where chronic symptoms predominantly reflect "intra-psychic pain" and "arrested or deviant development" which are not permanently helped by other forms of treatment, and who fulfill "criteria for analyzability . . . which include the capacity to form, maintain, and eventually relinquish an

adequate therapeutic alliance." This may be "evidenced by adequate potential for introspection, sublimation, self-object differentiation, and internal object constancy." Explicit criteria might equally well be developed for the use of behavior therapies, biofeedback, and nondirective Rogerian treatment. In any case, the criteria sets should describe indications for treatment, exceptions, critical diagnostic and therapeutic services, and how length-of-stay in treatment is to be determined.

EXPLICIT VS. IMPLICIT

Explicit criteria specify predetermined elements of care which apply to members of an entire group. The group may be characterized by diagnoses such as schizophrenia, alcoholism, or tardive dyskinesia; by problem specificity such as child abuse, suicide, or rape; or by generic treatment condition such as entry into inpatient, day, or ambulatory treatment or the use of psychopharmacological agents. In some situations, criteria may be based upon sociodemographic characteristics, such as social class, race, or age group. They may be normative or empirical. These criteria are *group standards* evolved from examination of community practice, established by an expert panel, or based upon research data. Such an approach is useful in comparing an individual's clinical care to community standards or ideal treatment.

Implicit standards allow change to be assessed on a case-by-case basis. They constitute an individualized approach to analyzing care and are the criteria most frequently used in reviewing a clinical chart or commenting on the quality of care during supervision or case rounds. Implicit criteria are most useful when criteria for a group are hard to define, or when group definition is less important than patient-clinician interaction. They tend to reflect the "art of practice" and are based upon the clinical experience of an individual practitioner, or group of practitioners. Implicit standards are usually not written down.

In general, clinicians tend to feel that "clinical judgment" is most useful because the art of their practice is built around a constant awareness of what is unique about each case. Reviewers, particularly insurers and accrediting bodies, insist upon explicit criteria. Quality assurance programs will also tend to rely upon review based on explicit criteria.

Implicit criteria, with difficulty, can be made explicit to provide an organized review of care. Kiresuk's Goal Attainment Scaling (Kiresuk and Sherman 1968) has been utilized for this purpose by forcing the clinician to define the basis of his judgment. In Goal At-

tainment Scaling, individual treatment goals are set for a patient's various problem areas and best possible outcomes and other points along a continuum are defined. Care provided the patient is evaluated in terms of goals defined at admission either by the clinician alone or through some interaction of client and clinician. The approach has been widely utilized in CMHCs in conjunction with problem-oriented records. An example combining problem-oriented criteria and Goal Attainment Scaling is provided in figure 18.

Goal Attainment Scaling has been used primarily to assess the outcome of services provided to individual patients. Since the goals vary from case to case, one cannot examine treatment in relation to predefined explicit criteria. The technique, however, could be used as a first step in criteria development. Through a careful examination of the treatment provided to numbers of individuals, information about specific types of problems or client groups can be abstracted in order to develop explicit criteria reflecting group standards.

TESTING AND VALIDATING CRITERIA

While information derived from both normative and empirical sources can be used to formulate criteria, the criteria ultimately reflect normative judgments. This situation poses several problems in the mental health area. Mental health practitioners tend to prefer particular therapeutic modalities, choose to deal with certain kinds of patients, and show interest only in specific problem areas, excluding others. These biases about treatment strategies and theoretical positions are compounded by a lack of consensus regarding basic definitions of health, mental health, and mental illness. Given this reality, the criteria adopted should be periodically tested and validated. If this does not occur, the criteria may become reified "laundry lists" that constrain clinical practice without assuring clinical excellence.

In view of this circumstance, retrospective review processes (see Chapters Four and Five) should be used to regularly evaluate the utility and validity of criteria. As retrospective review mechanisms, clinical care evaluation studies and profile analyses provide important vehicles for determining whether actual practice conforms to group standards and for testing whether the group standards adequately identify problems in the delivery of care. An excellent example of the use of clinical care evaluation studies in refining criteria was provided by Kirstein and Weissman (1976) in their review of criteria for hospitalization of suicidal patients. They were able to reduce a comprehensive list of behaviors to those few that

FIGURE 18

Problem-Oriented Criteria Development Using Goal Attainment Scaling

PROBLEM: *Depression*

Subjective: *"I feel down in the dumps and tired all of the time." Difficulty falling asleep nightly. 9 lbs. weight loss during past 12 months. Occasional suicidal thoughts.*

Objective: *Sad facies; tearful during interview. Exhibits psychomotor retardation.*

Assessment: *65 year old, dates onset of dysphoria to death of wife 18 months ago. Became tearful in talking about her.*

Plan:

1) Begin antidepressant meds.
2) 1 × /wk individual therapy
3) Encourage involvement in activities outside of the home.

GOAL AND GOAL WEIGHT 4

most unfavorable treatment outcome thought likely −2	*Becomes anergic, withdrawn and preoccupied to the point that he can no longer care for self. Despondency leads to active suicidal thoughts.*
less than expected success with treatment −1	
expected level of treatment success 0	*Occasional periods of sadness and tearfulness, particularly around anniversary events. Appetite returns. Only rare difficulty falling asleep. Can care for self, but remains socially disengaged.*
more than expected success with treatment +1	*No vegetative symptoms, suicidal ideation, bouts of tearfulness. Sad on occasion, but no apathy. Level of social interaction returns to prior state. Sees friends at least 2 × /wk. Involved in church and business as before wife's death.*
best anticipated success with treatment +2	

are most important for determining whether to hospitalize suicidal patients.

CAVEATS RELATED TO PEER REVIEW

The review coordinator examines indicators for admission to treatment or continued stay in the light of criteria developed by peer groups. The coordinator has only the power to determine whether decisions about care meet pre-established criteria. Those cases where deviations exist must be referred for peer review.

The term "peer review" implies that one's colleagues, one's equals, will cooperatively examine clinical practices in order to assure the quality of service, monitor appropriate utilization, and restrain cost. In the professions, peers are defined as members of the same discipline in order to maintain professional self-determination.

In many mental health settings there is serious confusion between peer review and administrative control issues. The need for a peer review process arose specifically from the role of physicians in general hospital settings. The physician serves as a relatively autonomous professional in most hospitals. He is paid not by the hospital, but directly by the patient. He has a powerful impact upon the hospital, since through his admissions practices he generates revenue for the hospital and commits hospital resources. Peer review practices require accountability mechanisms for physician behaviors. Significantly, physicians who work as hospital employees have tended to insist upon equivalent autonomy, as have other professionals. Institutions generally are loath to give up control to those who are already clearly accountable within institutional monitoring structures (e.g., supervision or clearly defined team structures with identified leadership). In fact, institutions may tend to subvert peer review practices in order to assert further administrative control over practice. Thus, added to issues of peer definition by discipline is the institutional wish to define accountability hierarchically.

In some settings, clinical administrative supervision is inappropriately identified as peer review. This stance leads either to subversion of institutional goals, as practitioners use these processes to define priorities and institutional policies, or, more commonly, to institutional constraint upon practice, as the institution adopts criteria and standards which limit clinical options and professional autonomy.

Peer review as identified in PSRO legislation is designed to preserve professional self-determination through professional monitoring of utilization, quality, and cost. It seeks to correct prob-

lems in practice through careful monitoring, persuasion, and education. Peer review is not hierarchical accountability.

The processes of review influence decisions about care and must be appreciated. Peer reviewers must live within the context of their professions. They will thus tend to show latitude in regard to deviations from practice as long as those deviations do not lead to patient care that is overtly bad. However, the process of recording information and examining the record will assure that clearly aberrant patterns of care are recognized and subject to review. When peers within a clinical setting have participated in defining criteria, or at least have agreed to accept criteria, they can be held accountable for their practices by their peer group. In this process, practitioners whose work is seriously aberrant will be identified, and mechanisms will be available for corrective action.

The reluctance of clinician reviewers to criticize the work of peers may be modified through effective interaction of the review coordinator and the clinician reviewer. Review coordinators have been able to focus the attention of clinician reviewers so that when admissions are being justified or extensions given which do not meet the criteria, the peer reviewer is committed to careful re-examination before further deviations from criteria are accepted.

Most often, the process of peer review and correction will be one of mutual respect, gentle persuasion, and education. When specific sanctions are required, they should be based upon documented or repeated deviations from accepted practice and should reflect a formal action of the relevant peer group.

The importance of confidentiality in this process must be emphasized. Records of peer review activities must be kept separate from case records. Access to records must be strictly limited by formally prescribed regulations.

The goal of peer review is assuring quality, and disciplinary actions occur only after confidential communication from peer to peer about identified deviance and efforts at education and correction. Professional practitioners cannot be expected to participate voluntarily in a program in which every suspected deviation from criteria is subject to public scrutiny. Federal regulations recognize this problem and in the PSRO process call for security of records (Curran 1978).

REFERENCES

American Psychiatric Association, Peer Review Committee. *Manual of Psychiatric Peer Review*. Washington, D.C.: The Association, 1976.

American Psychiatric Association. Adler, D.; Brauer, L.; Harrow, M.; Schwartz, A.; Schwartz, C.; Tucker, G. *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition—DSM III). Washington, D.C.: The Association, 1980.

Curran, W. J. Confidentiality of records in PSRO's. *New England Journal of Medicine*, 299:1348-1349, 1978.

Donabedian, A. Evaluating the quality of medical care. *Milbank Memorial Fund Quarterly*, 44:166-206, 1966.

Kiresuk, T. J., and Sherman, R. E. Goal attainment scaling: A general method for evaluating comprehensive community mental health programs. *Community Mental Health Journal*, 4:443-453, 1968.

Kirstein, L., and Weisman, M. M. Utilization review, attempted suicide and involuntary hospitalization. *Journal of Nervous and Mental Diseases*, 163:102-107, 1976.

Wagner, E. H.; Greenberg, R. A.; Umrey, P. B.; Williams, C. A.; Wolf, S. H.; and Ibrahim, M. A. Influence of training and experience on selecting criteria to evaluate medical care. *New England Journal of Medicine*, 294:871-876, 1976.

CHAPTER FOUR

THE RETROSPECTIVE REVIEW PROCESS— Profile Analysis

This chapter details retrospective review activities and focuses on problems in the delivery of care. The first method of retrospective review is profile analysis. Profiles are summaries of selected information drawn from cases and are used to identify and compare patterns of care. Methods of collecting and examining data are presented.

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KEY TOPICS

- The nature of retrospective review
- One method of retrospective review
- The development of a profile
- The major uses of profile analysis

CHAPTER FOUR

THE RETROSPECTIVE REVIEW PROCESS— Profile Analysis

Concurrent review activities focus on individual patients. The question of whether treatment or continued care is necessary is addressed on a case-by-case basis. A single episode of care is the point of reference. The review occurs while a person is still in treatment, and the outcome can have an immediate impact on the course of treatment.

Retrospective review activities, on the other hand, focus on the delivery of care to a large number of patients. While the data used in the retrospective review may be obtained during treatment, the analysis is usually conducted after discharge. The review is not intended to produce immediate results, but rather to promote a more effective and efficient use of available resources in a manner consistent with patient needs and professionally recognized standards of care. At present, two methods of retrospective review, *profile analysis* and *clinical care evaluation studies* are receiving the greatest attention.

PROFILE ANALYSIS

A profile is a summary that presents selected information so that patterns of care can be identified and analyzed. An individual profile displays information on a single patient or clinician. When the data

are aggregated by service unit or by categories of patients or clinicians, they comprise an institutional profile. Profiles from one institution can be compared with profiles of other institutions in order to assess performance.

Profile Development

The source material for profile development consists of data routinely collected on all patients and readily obtainable from the record. These data include information that (1) identifies patients, clinicians, and service units; (2) indicates the nature of the problem for which treatment services are offered; and (3) specifies the disposition and outcome of treatment. When computerized records are available, data may be obtained directly from the clinical record. Otherwise, clinical staff can abstract the requisite data from the record at the time of a patient's discharge.

Figure 19 illustrates a form for abstracting data from the record. Profiles can then be constructed either manually or by entering the data from the abstract into a suitably programmed computer.

The task of constructing an abstract can be facilitated if special forms are used for admission certification and continued-stay review (see sample forms in figures 20 and 21). These forms are completed by the clinician or the review coordinator during the concurrent review process. They serve two purposes: (1) providing ready access to information essential for determining the need for treatment or continued care and (2) providing the information required for profile development. Although for some profiles it may be necessary to go back to the record and abstract supplemental data, careful preplanning of review forms can save a great deal of time in the collection of evaluative information.

A profile is usually presented in the form of a statistical report of selected data on patients, practitioners, or service units in relation to specific questions concerning service delivery. For example, the data may be aggregated by clinicians in order to compare differences among clinicians in treating patients of a certain age with a particular diagnosis. Alternatively, the data may be aggregated by service units in order to compare patterns of care provided patients with similar diagnoses. The potential formats for profiles are limited only by the nature of the data available for profile development and the answers wanted about patterns of care (See figure 22).

Profile Analysis

The process of comparing patterns of care among clinicians or patients, comparing current patterns of care with those of a previous

FIGURE 19
An Example of an Abstract to be used for Profile Development

1. CASE NUMBER: ___/___/___/___/___/___/___
2. SERVICE UNIT: ___/___/___
3. PRIMARY CLINICIAN: ___/___/___
4. ADMITTED: ___/___/___ DISCHARGED: ___/___/___
5. LOS: ☐ Inpatient days = =
   PH Days = =
   OPD Visits = =
6. LEGAL STATUS: informal = =
   volun = =
   involun = =
7. FINAL DIAGNOSES:
   _____ ___/___/___•___/___
   _____ ___/___/___•___/___
   _____ ___/___/___•___/___
8. AGE: ☐ 9. SEX: = = M = = F
10. ETHNIC GROUP: = = white = = black = = hispanic
    = = am ind = = oriental = = other
11. MARITAL STATUS: = = nev mar = = mar = = remar
    = = sep = = div = = wid = = unk
12. HOUSEHOLD COMPOSITION: = = lvg alone = = with spouse
    = = with parents = = with children = = with sibs
    = = with oth rela = = with others = = in institu
13. WEEKLY FAMILY INCOME (Ave net dollars):
    = = welf = = <$50 = = $50-99 = = $100-149
    = = $150-199 = = $200-299 = = $300 +
14. INDIVIDUALS ON FAMILY INCOME: ☐
15. PAYMENT STATUS: = = workm comp = = blue cr
    = = comm insur = = pv = = medicare = = medicaid
    = = govt agen = = vol char = = other
16. DISCHARGE STATUS: = = with approval
    = = without appro
    = = trans
17. COMPLICATIONS: = = none = = present
    _____ ___/___/___
    _____ ___/___/___
    _____ ___/___/___
18. CONSULTATIONS: = = none = = med = = surg
    = = neuro = = other
19. INVESTIGATIVE SERVICES:

LAB	RADIOLOGY	FUNCTIONAL
= = cbc	= = resp	= = psych test
= = urn	= = cns	= = EKG
= = _____	= = _____	= = EEG
= = _____	= = _____	= = _____
= = _____	= = _____	= = _____
= = _____	= = _____	= = _____

20. THERAPEUTIC SERVICES:

MEDICATIONS	OTHER	
= = maj tranq	= = _____	= = _____
= = anti dep	= = _____	= = _____
= = min tranq	= = _____	= = _____
= = sedative	= = _____	= = _____
= = _____	= = _____	= = _____
= = _____	= = _____	= = _____
= = _____	= = _____	= = _____

21. REVIEW STATUS: = = adm cert appr = = adm cert disap
    = = cl rev app = = cl rev disap
    = = csr appr = = csr disap
    = = cl rev app = = cl rev disap
    = = conf appr = = conf disap

FIGURE 20

An Example of a Form for Use in Admission Certification

NAME: _____ DOB: ___/___/___ CASE NO:_____

SERVICE UNIT: ___/___/___ PRIMARY CLINICIAN: ___/___/___

DIAGNOSTIC IMPRESSION: _____ LEGAL STATUS: = = informal
_____ = = volun
_____ = = invol

CLINICAL EVIDENCE IN SUPPORT OF DIAGNOSIS: _____
_____
_____
_____

INDICATIONS FOR ADMISSION:	ELABORATE & EXPLAIN
= = actual or potential danger to self = = actual or potential danger to others = = behavior intolerable to client, family, or community = = removal of patient from psychonoxious environment = = impairment of social, familial, or occupational functioning = = supportive measures have been unsuccessful in halting or reversing the course of the mental disorder = = medications or drugs on which the patient is dependent must be withdrawn = = impaired reality testing accompanied by disordered behavior = = condition other than mental disorder requires hospital care, but psychological components cannot optimally be handled on other services = = inability to care for self and absence of social supports = = no alternative resources available = = need for 24 hour observation to clarify diagnosis or to evaluate condition in order to modify treatment procedures = = need for specialized treatment under 24 hour supervision	

= = approved
REVIEWED BY _____ ON ___/___/___ = = more information required
= = physician review required

PHYSICIAN REVIEW ON ___/___/___ BY_____
= = approved = = disapproved = = conference required

CONFERENCE RESULTS: _____
_____
_____

FIGURE 21

A Form for Requesting Extended Duration of Stay

Name: _____ _____ DOB: ___/___/___ Case #: _____

Admission Date: ___/___/___ Review Date: ___/___/___

Diagnosis: _____

Investigative Services Performed:

LABORATORY	RADIOLOGIC	FUNCTIONAL
___CBC	___chest/respiratory	___med h./phys xam
___STS	___skull	___psych h./ment status
___Urinalysis	___other, specify	___psychological tests
___toxicology screen	___	___EKG
___other, specify	___	___EEG
___	___	___other, specify
___	___	___
___	___	___
___	___	___
___	___	___

Therapeutic Services Provided:

MEDICATIONS	OTHER
_____	___ Nursing care
_____	___ ECT
_____	___ Casework with family
_____	___ OT
_____	___ RT
_____	___ Art Therapy
_____	___ Music Therapy
_____	___ Milieu Therapy
_____	___ Voc Counseling
_____	___ Genetic Counseling
_____	___ Ind Psychotherapy
_____	___ Gp Psychotherapy
_____	___ Family Psychotherapy
_____	___ Couples Psychotherapy
_____	___ Behavioral Therapy
_____	___ Other, specify

Consultations Obtained:

_____ _____
_____ _____
_____ _____

FIGURES 21 (Cont.)

A Form for Requesting Extended Duration of Stay

Complications (list type and date):

_____ _____

_____ _____

_____ _____

Discharge is not yet possible because:	EXPLAIN
= = persistence of disabling symptoms = = concomitant physical illness = = adverse reaction to medication, ECT = = hospital treatment career demonstrating lack of discharge readiness, e.g., elopement, suicide attempt, etc. = = major unanticipated life stress = = environmental factors of sufficient intensity and severity to immediately cause decompensation = = initial treatment goals not realized = = treatment program had to be modified = = discharge difficulties related to family/community rejection = = discharge difficulties related to absence of appropriate resources in the community = = planning for alternate care not complete = = awaiting economic support arrangements = = transfer pending = = other, please specify	

Estimate of additional days of hospital level care required: _____

REVIEWED BY _____ ON ___/___/___: = = more information required
= = physician review required
= = approved

PHYSICIAN REVIEW ON __/__/__ BY _____: = = approved
= = disapproved
= = conference required

CONFERENCE RESULTS: _____

FIGURE 22

Examples of Profile Displays

SVC UNIT	ALL PTS DISCH # LOS	EMERG. #	COMPL. #	CONSUL #	AGE < 20 #	AGE < 20 LOS	AGE > 65 #	AGE > 65 LOS	PAYMENT STATUS Work Comp # LOS	PAYMENT STATUS Blue Cross # LOS
131	50 6.5	24	10	8	5	15.1	12	10.3		25 7.2
132	22 18.6	8	2	2	5	15.1	3	28.6		10 18.8
133	22 27.5	15	11	12						

A summary profile by service unit

SVC UNIT 131 ALL PTS DISCH

BENJAMIN RUSH CMHC

PRIM CLINI # LOS	DIAG	CASE NO	LOS	ADM EMEG	LEG STAT 1	LEG STAT 2	LEG STAT 3	AGE	SEX
abc 10 4.3	SCHIZO								
		139521	8	Y		X		18	M
		167345	3	Y		X		27	F
		198459	15		X			67	M
	AFF DIS	198723	12	Y		X		34	F
		198734	1		X			17	M
	NEURO								
	TRANS SIT								
	PERS DISOR	198756	2	Y	X			22	M
		169543	3						

Profile displayed as a listing of patients by primary clinician by service unit

time, and comparing patterns of care between institutions or service units is referred to as "profile analysis." This technique for surveying patterns of care is used to monitor service delivery trends and identify deviations from expected or desired practice. Analyses can be used:

1. To focus concurrent review on problem areas. For example, a profile may reveal that admission rates and lengths of stay for patients with a diagnosis of depressive neurosis treated on an inpatient unit of a community mental health center fall within the norms for

that condition in that region. This could prompt the reviewers to grant automatic certification of admission for this diagnosis, using the profile system periodically to monitor performance. Conversely, a profile might show abnormally high lengths of stay for adolescent patients with the diagnosis of depressive neurosis. This could lead the institution to intensify admission certification and continued-stay review efforts for this group of patients. Age-specific criteria could be developed, and a 100-percent review of all patients admitted undertaken.

2. To establish priorities for clinical care evaluation studies. A comparison of service units might reveal that patients with a diagnosis of schizophrenia treated on Ward A as opposed to Wards B, C, and D have a significantly longer LOS and a greater number of complications during their hospitalization. Such information may suggest the need for more indepth inquiry concerning the character of care provided patients with the diagnosis. The clinical care evaluation study provides an appropriate vehicle for such an inquiry.

3. To aid in monitoring the impact of an institution's review activities. For example, the results of the clinical care evaluation study suggested above raised questions about the use of major tranquilizers on Ward A, where the initiation of psychotropics was delayed and dose levels were felt to be homeopathic. Based on the study, a 100-percent screening benchmark for major tranquilizer use in the inpatient treatment of patients with diagnosis of schizophrenia was established. A continuing education seminar on psychopharmacology was also instituted. To determine whether the actions led to any measurable shift in the patterns of care initially observed, a second profile analysis was conducted some 6 months later. In the comparison of the four treatment units, no major variation in the length of stay was found, and the length of stay for all units was consistent with regional norms. The incidence of complications in Ward A had decreased significantly since the first profile analysis. On the basis of these analyses, it was concluded that the corrective actions taken were associated with acceptable change in the pattern of care within the institution.

CHAPTER FIVE

THE RETROSPECTIVE REVIEW PROCESS— Clinical Care Evaluation Studies

This chapter explains retrospective review conducted through Clinical Care Evaluation (CCE) studies. These studies are attempts to establish parameters of legitimate clinical conduct in relation to a problem, population, or program that is the topic of inquiry. The authors identify the various components of care which can be studied, explain how to select study topics, and establish criteria and standards for CCE studies.

KEY TOPICS

- The nature of the Clinical Care Evaluation study
- Organization of CCE studies
- Objectives of the CCE studies
- Implementation of CCE studies
- Uses of CCE studies

CHAPTER FIVE

THE RETROSPECTIVE REVIEW PROCESS— Clinical Care Evaluation Studies

Clinical Care Evaluation (CCE) studies are a form of retrospective review in which an indepth assessment is made of a particular problem or set of problems to determine whether patients are receiving the type of care defined by an institution as appropriate and adequate and whether the outcome of care is of an acceptable level. Generally, these studies focus on an identified or suspected problem area, cover a short period of time, and deal with the care provided by a number of practitioners to a number of patients. The objective is to provide information on the process of care and performance of clinicians that is sufficiently detailed and definitive to be used for prescribing interventions or changes that will benefit patient, institution, and community. The steps in a CCE study include:

1. **Identification of components of care to be studied.**

   This step involves the selection of a component of care of sufficient importance to warrant indepth study. A topic may be suggested by profile analysis or concurrent review or by critical issues raised by staff, specialty societies, or community board.

Study topics might concern the care provided patients with a particular diagnosis or problem or they might be therapy-centered. For example, the infrequent use of group therapy in an outpatient setting could be questioned. What are the criteria for referral to a group? Are there identifiable differences between persons referred to group and other forms of outpatient therapy? Do administrative procedures facilitate or inhibit the referral process? What kinds of group therapy are offered? Who seems to benefit from group therapy?

Similarly, diagnostic procedures could be the subject of inquiry—the use of psychological testing for patients with a diagnosis of minimal brain dysfunction or the workup of patients being considered for ambulatory electroconvulsive therapy, for example. Utilization practices could be examined. Are the clients utilizing a program representative of the social demography of a service area? Does movement from one level of care occur when indicated? Studies may concentrate on administrative issues, such as Incident Reports, the organization of emergency services, or problems of scheduling and reporting consultations for laboratory and X-ray studies. Treatment outcomes could also be a topic of inquiry.

Since the range of topics is nearly infinite, every effort should be made to select study areas on the basis of importance, visibility, adequate sample size, and probable utility of results in formulating recommendations for change.

2. Establishment of criteria and standards for the study.

Unlike clinical research that seeks to determine whether treatment A is more efficacious than treatment B, clinical care evaluation studies look at whether the process of care contributes to or diminishes the assumed efficacy of treatment services. CCE studies are designed to answer questions such as: Are patients receiving the appropriate type of care? Are treatment outcomes at an acceptable level? Does the organization and administration of care enhance the efficiency of treatment without detracting from its effectiveness? To answer these or

other questions relating to the study topic, benchmarks must be constructed which identify efficacious procedures, optimal outcomes, or ideal organization. In other words, criteria are used to measure the extent to which the actual delivery of care conforms with the optimal delivery of care.

The specificity of criteria required for CCE studies should be of a higher order than that required for screening criteria used in concurrent review. If the study topic, for example, involves the appropriate use of psychotropic medications in an ambulatory setting, the criteria might specify effective dose ranges, drug interactions which may cause serious symptoms, or the relationship between drug class and diagnosis in order to determine the appropriateness of pharmacological interventions. The criteria can be incorporated in a checklist, such as the example in figure 23, which facilitates abstracting the required information from a chart.

In other instances, a population-specific focus might be adopted. A CCE study on the outpatient treatment of adolescents, for instance, began with the assumption that a therapeutic intervention could be judged adequate *only* if parents were actively involved. Criteria were then developed stipulating the circumstances under which exceptions to parental involvement could be made. For instance, parents could be excluded if the adolescent's life situation was not chaotic, the adolescent was an emancipated minor, or the clinician judged that parental involvement during the initial evaluation would preclude the development of the therapeutic alliance.

As these examples indicate, the criteria used in clinical care evaluation studies attempt to establish the parameters of legitimate clinical conduct in relation to a particular problem, population, modality, or program. The criteria themselves can be adopted from criteria sets developed by major national specialty societies. They can reflect the opinion of experts as noted either in textbooks or journals or be based on evidence from clinical research studies. They can also be developed from aggregate data depicting patterns of care within a particular institution. Since regional variation exists in treatment practices, the availabil-

FIGURE 23

A Format for Abstracting Information on Psychotropic Drug Use for a CCE Study (Based on DSM II)

1. Does the chart indicate the following:
   a. names of medication(s)
   b. dosages
   c. side effects or absence thereof
   d. efficacy or absence thereof
2. If medication was prescribed and adequately recorded, was it:
   a. a minor tranquilizer?

      If YES, was the diagnosis alcohol psychosis, neurosis, personality disorder, sexual deviation, alcoholism, drug dependence, psychophysiologic disorder, special symptoms not elsewhere classified, transient situational disturbances, nonpsychotic organic brain syndrome with alcohol or social malajustment?

   b. a major tranquilizer?

      If YES, was the diagnosis psychosis associated with organic brain syndrome, schizophrenia, major affective disorder, paranoid states, or other psychoses?

   c. an antidepressant?

      If YES, was the diagnosis involutional melancholia, manic depressive illness, depressed type (or circular type, depressed), other psychosis, or depressive neuroses?
3. Was a single generic variety of antidepressant given to the patient for more than 8 months?

   If YES, chart should be subject to review.
4. Has the patient received the same medication for longer than 3 months?

   If YES, do the total daily dosages prescribed exceed:

valium	20 mg	haldol	15 mg
librium	40 mg	navane	20 mg
miltown	1200 mg	thorazine	400 mg
		mellaril	400 mg
elavil	150 mg	trilafon	32 mg
tofranil	200 mg	stelazine	30 mg
		prolixin	10 mg

   If YES, chart should be subject to review.
5. Has the patient received the following medication in total daily dosages not exceeding those indicated for a period of more than 6 months?

valium	5 mg		
librium	10 mg	thorazine	50 mg
miltown	400 mg	mellaril	50 mg
elavil	50 mg		
tofranil	50 mg		

   If YES, chart should be subject to review.

Adapted from the Chart Review Checklist of the Connecticut Mental Health Center, New Haven, Connecticut.

ity of resources, and the character of client populations being served, these issues should be taken into account in formulating criteria. However, clinicians responsible for the delivery of care should participate in selecting the final criteria. Involving those persons whose work is being judged in the selection of criteria usually makes the results more readily accepted.

3. Design study and information requirements.

The study designer must designate a study site; specify sample size and the characteristics of the population to be studied; select the sources of information and instruments; determine whether data will be collected prospectively, retrospectively, or both; indicate data-collection procedures; and select the data-processing mechanisms to be used.

Much of the data used in CCE studies will be obtained from the chart. Once study criteria are established, therefore, it is important to develop an instrument for abstracting material from the record. An abstract allows for a rapid and accurate presentation of data related to the problem being studied and helps to ensure the collection of all necessary data.

In some instances, however, CCE studies will use data sources other than the chart. Since this information is not routinely available, the decision invariably implies a prospective design. Whether one collects information at time of admission, discharge, or followup, the resource requirements for such a study will be greater than when all data are obtained from the record. Numerous instruments have been developed to measure clinical status, social adjustment, and the like that can be helpful in prospective studies of this type. Examples are provided in figures 24-27 (pages 74-95). For a more exhaustive inventory, the reader is referred to *Resource Materials for Community Mental Health Program Evaluation* (Hargreaves et al. 1979).

4. Collect and present data.

The collection of data and the organization and presentation of the material should be done primarily by clerical and administrative personnel, since these tasks involve mainly tabulation, summarization, and, where appropriate, statistical analysis. Once tabu-

lated, the results are presented to the Quality Assurance Committee. At this point, the study consists of "facts" alone.

5. Analyze data and prepare report.

In the next step, findings are reviewed by the Quality Assurance Committee. The Committee's analysis and discussion are aimed at developing conclusions leading to the formulation of concrete recommendations for change. The "facts," conclusions, and recommendations comprise the heart of a study report. In preparation of the report, it is important to bear in mind how the results can be used:

a. To monitor the effectiveness of admission certification and continued-stay review and identify areas where concurrent review processes should be instituted or intensified;

b. To identify the needed changes in the organization and administration of care in order to assure a more effective and efficient response to the needs of users and potential users of services;

c. To develop curriculum and monitor the effectiveness of educational activities aimed at correcting identified problems relating to the delivery of care; and

d. To provide information that will allow judgments regarding the adequacy of existing criteria, norms, and standards and the development of new criteria, norms, and standards.

The objective of the study is to monitor the delivery of service, identify deficiencies in the process and outcome of care, determine the causes of these deficiencies, and develop a corrective plan. Depending on the nature of the deficiency identified, the plan may involve organizational or educational interventions.

6. Distribute study and provide followup.

The study report, including its recommendations, should be forwarded to those groups and personnel specified in the written utilization review plan as described in Chapter Eight and to any others directly

concerned with the subject and recommendations. At a reasonable time after corrective actions are completed, a re-evaluation should be undertaken to assure that appropriate changes have occurred. This follow-up should be a brief study of the identified problem or a profile analysis. Technically a clinical care evaluation study is not complete until this final step has been accomplished.

REFERENCES

Hargreaves, W. F.; Attkisson, C. C.; and Sorensen, J.E. Resource Materials for Community Mental Health Program Evaluation. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1979 (ADM) 79-328.

FIGURE 24

Global Assessment Scale (GAS)

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Global Assessment Scale (GAS)

Robert L. Spitzer, M.D., Miriam Gibbon, M.S.W., Jean Endicott, Ph. D.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30), should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 62). Rate actual functioning independent of whether or not subject is receiving and may be helped by medication or some other form of treatment.

Name of Patient _____ ID No. _____ Group Code _____

Admission Date _____ Date of Rating _____ Rater _____

GAS Rating: _____

100 | 91 Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity. No Symptoms.

90 | 81 Good functioning in all areas, many interests, socially effective, generally satisfied with life. There may or may not be transient symptoms and "everyday" worries that only occasionally get out of hand.

80 | 71 No more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand. Minimal symptoms may or may not be present.

70 | 61 Some mild symptoms (e.g., depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick."

60 | 51 Moderate symptoms OR generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).

50 | 41 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking, mild but definite manic syndrome).

40 | 31 Major impairment in several areas, such as work, family relations, judgment, thinking or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (e.g., speech is at times obscure, illogical or irrelevant), OR single suicide attempt.

30 | 21 Unable to function in almost all areas (e.g., stays in bed all day) OR behavior is considerably influenced by either delusions or hallucinations OR serious impairment in communication (e.g., sometimes incoherent or unresponsive)or judgment (e.g., acts grossly inappropriately).

20 | 11 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (e.g., largely incoherent or mute).

10 | 1 Needs constant supervision for several days to prevent hurting self or others (e.g., requires an intensive care unit with special observation by staff), makes no attempt to maintain minimal personal hygiene, or serious suicide act with clear intent and expectation of death.

Source: Endicott, J.; Spitzer, R. I.; Fleiss, J. L.; and Cohen, J. The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry*, 33:766-711, 1976. Reprinted with permission of the copyright holder. Copyright © 1972-76, American Medical Association.

FIGURE 25

A Self-administered Symptom Checklist: The SCL-90-R

SCL-90-R

Name: _____ Technician: _____ Ident. No. _____

Location: _____ Visit No.: _____ Mode: S-R_____ Nor____

Age: _____ Sex: M_____ F_____ Date: _____ Remarks: _____

INSTRUCTIONS

Below is a list of problems and complaints that people sometimes have. Read each one carefully, and select one of the numbered descriptors that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST_____INCLUDING TODAY. Place that number in the open block to the right of the problem. Do not skip any items, and print your number clearly. If you change your mind, erase your first number completely. Read the example below before beginning, and if you have any questions please ask the technician.

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely

Ex. Body Aches ..... Ex. [3] (Answer)

1. Headaches ..... ☐
2. Nervousness or shakiness inside ..... ☐
3. Repeated unpleasant thoughts that won't leave your mind ..... ☐
4. Faintness or dizziness ..... ☐
5. Loss of sexual interest or pleasure ..... ☐
6. Feeling critical of others ..... ☐
7. The idea that someone else can control your thoughts ..... ☐
8. Feeling others are to blame for most of your troubles ..... ☐
9. Trouble remembering things ..... ☐
10. Worried about sloppiness or carelessness ..... ☐
11. Feeling easily annoyed or irritated ..... ☐
12. Pains in heart or chest ..... ☐
13. Feeling afraid in open spaces or on the streets ..... ☐
14. Feeling low in energy or slowed down ..... ☐
15. Thoughts of ending your life ..... ☐
16. Hearing voices that other people do not hear ..... ☐
17. Trembling ..... ☐
18. Feeling that most people cannot be trusted ..... ☐
19. Poor appetite ..... ☐
20. Crying easily ..... ☐
21. Feeling shy or uneasy with the opposite sex ..... ☐
22. Feelings of being trapped or caught ..... ☐
23. Suddenly scared for no reason ..... ☐
24. Temper outbursts that you could not control ..... ☐
25. Feeling afraid to go out of your house alone ..... ☐
26. Blaming yourself for things ..... ☐
27. Pains in lower back ..... ☐

HOW MUCH WERE YOU DISTRESSED BY:

Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely

28. Feeling blocked in getting things done ..... ☐
29. Feeling lonely ..... ☐
30. Feeling blue ..... ☐
31. Worrying too much about things ..... ☐
32. Feeling no interest in things ..... ☐
33. Feeling fearful ..... ☐
34. Your feelings being easily hurt ..... ☐
35. Other people being aware of your private thoughts ..... ☐
36. Feeling others do not understand you or are unsympathetic ..... ☐
37. Feeling that people are unfriendly or dislike you ..... ☐
38. Having to do things very slowly to insure correctness ..... ☐
39. Heart pounding or racing ..... ☐
40. Nausea or upset stomach ..... ☐
41. Feeling inferior to others ..... ☐
42. Soreness of your muscles ..... ☐
43. Feeling that you are watched or talked about by others ..... ☐
44. Trouble falling asleep ..... ☐
45. Having to check and doublecheck what you do ..... ☐
46. Difficulty making decisions ..... ☐
47. Feeling afraid to travel on buses, subways, or trains ..... ☐
48. Trouble getting your breath ..... ☐
49. Hot or cold spells ..... ☐
50. Having to avoid certain things, places, or activities because they frighten you ..... ☐
51. Your mind going blank ..... ☐
52. Numbness or tingling in parts of your body ..... ☐

SAMPLE DO NOT DUPLICATE SAMPLE DO NOT DUPLICATE

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PAGE ONE

PLEASE CONTINUE ON THE FOLLOWING PAGE ▷

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FIGURE 25:

A Self-administered Symptom Checklist: The SCL-90-R (Cont'd.)

SCL-90-R

HOW MUCH WERE YOU DISTRESSED BY:	Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely
53. A lump in your throat	☐
54. Feeling hopeless about the future	☐
55. Trouble concentrating	☐
56. Feeling weak in parts of your body	☐
57. Feeling tense or keyed up	☐
58. Heavy feelings in your arms or legs	☐
59. Thoughts of death or dying	☐
60. Overeating	☐
61. Feeling uneasy when people are watching or talking about you	☐
62. Having thoughts that are not your own	☐
63. Having urges to beat, injure, or harm someone	☐
64. Awakening in the early morning	☐
65. Having to repeat the same actions such as touching, counting, washing	☐
66. Sleep that is restless or disturbed	☐
67. Having urges to break or smash things	☐
68. Having ideas or beliefs that others do not share	☐
69. Feeling very self-conscious with others	☐
70. Feeling uneasy in crowds, such as shopping or at a movie	☐

HOW MUCH WERE YOU DISTRESSED BY:	Descriptors: 0 Not at all; 1 A little bit; 2 Moderately; 3 Quite a bit; 4 Extremely
71. Feeling everything is an effort	☐
72. Spells of terror or panic	☐
73. Feeling uncomfortable about eating or drinking in public	☐
74. Getting into frequent arguments	☐
75. Feeling nervous when you are left alone	☐
76. Others not giving you proper credit for your achievements	☐
77. Feeling lonely even when you are with people	☐
78. Feeling so restless you couldn't sit still	☐
79. Feelings of worthlessness	☐
80. The feeling that something bad is going to happen to you	☐
81. Shouting or throwing things	☐
82. Feeling afraid you will faint in public	☐
83. Feeling that people will take advantage of you if you let them	☐
84. Having thoughts about sex that bother you a lot	☐
85. The idea that you should be punished for your sins	☐
86. Thoughts and images of a frightening nature	☐
87. The idea that something serious is wrong with your body	☐
88. Never feeling close to another person	☐
89. Feelings of guilt	☐
90. The idea that something is wrong with your mind	☐

SAMPLE DO NOT DUPLICATE

Source: Derogatis, L. R. The SCL-90 Manual I: Scoring Administration and Procedures for the SCL-90-R. Baltimore: Clinical Psychometrics Research, 1977. The SCL-90-R is reprinted with permission of the author and copyright holder, Leonard R. Derogatis, Ph.D., Director, Division of Medical Psychology, Johns Hopkins University School of Medicine. Requests for the Administration Manual, further information, or order forms for the instrument should be addressed to Dr. Derogatis, c/o Clinical Psychometric Research, 1228 Wine Spring Lane, Towson, Maryland 21204.

FIGURE 26

A Social Adjustment Self-Report

The Social Adjustment Self-Report form was developed by Myrna Weissman, Ph.D. and her colleagues at the Depression Research Unit, Department of Psychiatry, Yale University School of Medicine under contract with the Alcohol, Drug Abuse and Mental Health Administration, U.S. Department of Health and Human Services. For further information, see Weissman, M.M., and Bothwell, S. The assignment of social adjustment by patient self-report. *Archives of General Psychiatry.* 33:111-115, 1976.

FIGURE 26

Social Adjustment Self-Report

Study	Patient Number			Patient Initials			21	SAS-SR-Patient	Page 1 of 6
								Depression Research Unit	
cc 1	2	3	4	5	6	7			

Date _____

Rater's Initials: ☐☐ Computer Date ☐☐☐ ☐ (8-13)

SOCIAL ADJUSTMENT SELF REPORT QUESTIONNAIRE

We are interested in finding out how you have been doing in the last *two weeks*. We would like you to answer some questions about york work, spare time and your family life. There are no right or wrong answers to these questions. Check the answers that best describes how you have been in the last *two weeks*.

WORK OUTSIDE THE HOME

Please check the situation that best describes you.

I am 1☐ a worker for pay 4☐ retired (14)
2☐ a housewife 5☐ unemployed
3☐ a student

Do you usually work for pay more than 15 hours per week?

1☐ YES 2☐ NO (15)

Did you work any hours for pay in the last two weeks?

1☐ YES 2☐ NO (16)

Check the answer that best describes how you have been in the last two weeks.

1. How many days did you miss from work in the last two weeks?

1☐ No days missed. (17)
2☐ One day.
3☐ I missed about half the time.

5. Have you felt upset, worried, or uncomfortable while doing your work during the last 2 weeks?

1☐ I never felt upset. (21)
2☐ Once or twice I felt upset.
3☐ Half the time I felt upset.
4☐ I felt upset most of the time.
5☐ I felt upset all of the time.

6. Have you found your work interesting these last two weeks?

1☐ My work was almost always interesting. (22)
2☐ Once or twice my work was not interesting.
3☐ Half the time my work was uninteresting.
4☐ Most of the time my work was uninteresting.
5☐ My work was always uninteresting.

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4 ☐ Missed more than half the time but did make at least one day.

5 ☐ I did not work any days.

8 ☐ On vacation all of the last two weeks.

If you have not worked any days in the last two weeks, go on to Question 7.

2. Have you been able to do your work in the last 2 weeks?

1 ☐ I did my work very well. (18)

2 ☐ I did my work well but had some minor problems.

3 ☐ I needed help with work and did not do well about half the time.

4 ☐ I did my work poorly most of the time.

5 ☐ I did my work poorly all the time.

3. Have you been ashamed of how you do your work in the last 2 weeks?

1 ☐ I never felt ashamed. (19)

2 ☐ Once or twice I felt a little ashamed.

3 ☐ About half the time I felt ashamed.

4 ☐ I felt ashamed most of the time.

5 ☐ I felt ashamed all the time.

4. Have you had any arguments with people at work in the last 2 weeks?

1 ☐ I had no arguments and got along very well. (20)

2 ☐ I usually got along well but had minor arguments.

3 ☐ I had more than one argument.

4 ☐ I had many arguments.

5 ☐ I was constantly in arguments.

WORK AT HOME - HOUSEWIVES ANSWER QUESTIONS 7-12. OTHERWISE, GO ON TO QUESTION 13.

7. How many days did you do some housework during the last 2 weeks?

1 ☐ Every day. (23)

2 ☐ I did the housework almost every day.

3 ☐ I did the housework about half the time.

4 ☐ I usually did not do the housework.

5 ☐ I was completely unable to do housework.

8 ☐ I was away from home all of the last two weeks.

8. During the last two weeks, have you kept up with your housework? This includes cooking, cleaning, laundry, grocery shopping, and errands.

1 ☐ I did my work very well. (24)

2 ☐ I did my work well but had some minor problems.

3 ☐ I needed help with my work and did not do it well about half the time.

4 ☐ I did my work poorly most of the time.

5 ☐ I did my work poorly all of the time.

9. Have you been ashamed of how you did your housework during the last 2 weeks?

1 ☐ I never felt ashamed. (25)

2 ☐ Once or twice I felt a little ashamed.

3 ☐ About half the time I felt ashamed.

4 ☐ I felt ashamed most of the time.

5 ☐ I felt ashamed all the time.

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FIGURE 26

A Social Adjustment Self-Report (Cont'd)

Study	Patient Number	Patient Initials	21	SAS-SR-Patient	Page 2 of 6
				Depression Research Unit	

SOCIAL ADJUSTMENT SELF REPORT QUESTIONNAIRE (Page 2 of 6)

10. Have you had any arguments with salespeople, tradesmen or neighbors in the last 2 weeks? (26)

1☐ I had no arguments and got along very well.
2☐ I usually got along well, but had minor arguments.
3☐ I had more than one argument
4☐ I had many arguments.
5☐ I was constantly in arguments.

11. Have you felt upset while doing your housework during the last 2 weeks? (27)

1☐ I never felt upset.
2☐ Once or twice I felt upset.
3☐ Half the time I felt upset.
4☐ I felt upset most of the time.
5☐ I felt upset all of the time.

12. Have you found your housework interesting these last 2 weeks? (28)

1☐ My work was almost always interesting.
2☐ Once or twice my work was not interesting.
3☐ Half the time my work was uninteresting.
4☐ Most of the time my work was uninteresting.
5☐ My work was always uninteresting.

14. Have you been able to keep up with your class work in the last 2 weeks? (31)

1☐ I did my work very well.
2☐ I did my work well but had minor problems.
3☐ I needed help with my work and did not do well about half the time.
4☐ I did my work poorly most of the time.
5☐ I did my work poorly all the time.

15. During the last 2 weeks, have you been ashamed of how you do your school work? (32)

1☐ I never felt ashamed.
2☐ Once or twice I felt ashamed.
3☐ About half the time I felt ashamed.
4☐ I felt ashamed most of the time.
5☐ I felt ashamed all of the time.

16. Have you had any arguments with people at school in the last 2 weeks? (33)

1☐ I had no arguments and got along very well.
2☐ I usually got along well but had minor arguments.
3☐ I had more than one argument.

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FOR STUDENTS

Answer Questions 13-18 if you go to school half time or more. Otherwise, go on to Question 19.

What best describes your school program? (Choose one)

1 ☐ Full Time (29)
2 ☐ 3/4 Time
3 ☐ Half Time

Check the answer that best describes how you have been the last 2 weeks.

13. How many days of classes did you miss in the last 2 weeks?

1 ☐ No days missed. (30)
2 ☐ A few days missed.
3 ☐ I missed about half the time.
4 ☐ Missed more than half time but did make at least one day.
5 ☐ I did not go to classes at all.
8 ☐ I was on vacation all of the last two weeks.

4 ☐ I had many arguments.
5 ☐ I was constantly in arguments.
8 ☐ Not applicable; I did not attend school.

17. Have you felt upset at school during the last 2 weeks?

1 ☐ I never felt upset. (34)
2 ☐ Once or twice I felt upset.
3 ☐ Half the time I felt upset.
4 ☐ I felt upset most of the time.
5 ☐ I felt upset all of the time.
8 ☐ Not applicable; I did not attend school.

18. Have you found your school work interesting these last 2 weeks?

1 ☐ My work was almost always interesting. (35)
2 ☐ Once or twice my work was not interesting.
3 ☐ Half the time my work was uninteresting.
4 ☐ Most of the time my work was uninteresting.
5 ☐ My work was always uninteresting.

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FIGURE 26

A Social Adjustment Self-Report (Cont'd)

Study	Patient Number	Patient Initials	21 SAS-SF-Patient	Page 3 of 6
			Depression Research Unit	

SOCIAL ADJUSTMFNT SELF REPORT QUESTIONNAIRE (Page 3 of 6)

SPARE TIME – EVERYONE ANSWER QUESTIONS 19-27.

Check the answer that best describes how you have been in the last 2 weeks.

19. How many friends have you seen or spoken to on the telephone in the last 2 weeks?

1 ☐ Nine or more friends. (36)
2 ☐ Five to eight friends.
3 ☐ Two to four friends.
4 ☐ One friend
5 ☐ No friends.

20. Have you been able to talk about your feelings and problems with at least one friend during the last 2 weeks?

1 ☐ I can always talk about my innermost feelings. (37)
2 ☐ I usually can talk about my feelings.
3 ☐ About half the time I felt able to talk about my feelings.
4 ☐ I usually was not able to talk about my feelings.
5 ☐ I was never able to talk about my feelings.
8 ☐ Not applicable; I have no friends.

24. If your feelings were hurt or offended by a friend during the last two weeks, how badly did you take it?

1 ☐ It did not affect me or it did not happen. (41)
2 ☐ I got over it in a few hours.
3 ☐ I got over it in a few days.
4 ☐ I got over it in a week.
5 ☐ It will take me months to recover.
8 ☐ Not applicable; I have no friends.

25. Have you felt shy or uncomfortable with people in the last 2 weeks?

1 ☐ I always felt comfortable. (42)
2 ☐ Sometimes I felt uncomfortable but could relax after a while.
3 ☐ About half the time I felt uncomfortable.
4 ☐ I usually felt uncomfortable.
5 ☐ I always felt uncomfortable.
8 ☐ Not applicable; I was never with people.

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21. **How many times in the last two weeks have you gone out socially with other people? For example, visited friends, gone to movies, bowling, church, restaurants, invited friends to your home?** (38)

1 ☐ More than 3 times.
2 ☐ Three times.
3 ☐ Twice.
4 ☐ Once.
5 ☐ None.

22. **How much time have you spent on hobbies or spare time interests during the last 2 weeks? For example, bowling, sewing, gardening, sports, reading?** (39)

1 ☐ I spent most of my spare time on hobbies almost every day.
2 ☐ I spent some spare time on hobbies some of the days.
3 ☐ I spent a little spare time on hobbies.
4 ☐ I usually did not spend any time on hobbies but did watch TV.
5 ☐ I did not spend any spare time on hobbies or watching TV.

23. **Have you had open arguments with your friends in the last 2 weeks?** (40)

1 ☐ I had no arguments and got along very well.
2 ☐ I usually got along well but had minor arguments.
3 ☐ I had more than one argument.
4 ☐ I had many arguments.
5 ☐ I was constantly in arguments.
8 ☐ Not applicable; I have no friends.

26. **Have you felt lonely and wished for more friends during the last 2 weeks?** (43)

1 ☐ I have not felt lonely.
2 ☐ I have felt lonely a few times.
3 ☐ About half the time I felt lonely.
4 ☐ I usually felt lonely.
5 ☐ I always felt lonely and wished for more friends.

27. **Have you felt bored in your spare time during the last 2 weeks?** (44)

1 ☐ I never felt bored.
2 ☐ I usually did not feel bored.
3 ☐ About half the time I felt bored.
4 ☐ Most of the time I felt bored.
5 ☐ I was constantly bored.

Are you a Single, Separated, or Divorced Person not living with a person of opposite sex; please answer below:

(45)

1 ☐ YES, Answer questions 28 & 29.
2 ☐ NO, go to question 30.

28. **How many times have you been with a date these last 2 weeks?** (46)

1 ☐ More than 3 times.
2 ☐ Three times.
3 ☐ Twice.
4 ☐ Once.
5 ☐ Never.

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FIGURE 26

A Social Adjustment Self-Report (Cont'd)

Study	Patient Number	Patient Initials	21 SAS-SR-Patient Page 4 of 6
			Depression Research Unit

SOCIAL ADJUSTMENT SELF REPORT QUESTIONNAIRE (Page 4 of 6)

29. Have you been interested in dating during the last 2 weeks. If you have not dated, would you have liked to? (47)

1 ☐ I was always interested in dating.
2 ☐ Most of the time I was interested.
3 ☐ About half of the time I was interested.
4 ☐ Most of the time I was not interested.
5 ☐ I was completely uninterested.

FAMILY

Answer Questions 30-37 about your parents, brothers, sisters, in laws, and children not living at home. Have you been in contact with any of them in the last two weeks?

1 ☐ YES, Answer questions 30-37.
2 ☐ NO, Go to question 36

30. Have you had open arguments with your relatives in the last 2 weeks? (48)

1 ☐ We always got along very well.
2 ☐ We usually got along very well but had some minor arguments.
3 ☐ I had more than one argument with at least one relative.
4 ☐ I had many arguments.
5 ☐ I was constantly in arguments.

34. Have you wanted to do the opposite of what your relatives wanted in order to make them angry during the last 2 weeks? (52)

1 ☐ I never wanted to oppose them.
2 ☐ Once or twice I wanted to oppose them.
3 ☐ About half the time I wanted to oppose them.
4 ☐ Most of the time I wanted to oppose them.
5 ☐ I always opposed them.

35. Have you been worried about things happening to your relatives without good reason in the last 2 weeks? (53)

1 ☐ I have not worried without reason
2 ☐ Once or twice I worried.
3 ☐ About half the time I worried.
4 ☐ Most of the time I worried.
5 ☐ I have worried the entire time.
8 ☐ Not applicable; my relatives are no longer living.

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31. **Have you been able to talk about your feelings and problems with at least one of your relatives in the last 2 weeks?**

1☐ I can always talk about my feelings with at least one relative. (49)

2☐ I usually can talk about my feelings.

3☐ About half the time I felt able to talk about my feelings.

4☐ I usually was not able to talk about my feelings.

5☐ I was never able to talk about my feelings.

32. **Have you avoided contacts with your relatives these last two weeks?**

1☐ I have contacted relatives regularly. (50)

2☐ I have contacted a relative at least once.

3☐ I have waited for my relatives to contact me.

4☐ I avoided my relatives, but they contacted me.

5☐ I have no contacts with any relatives.

33. **Did you depend on your relatives for help, advice, money or friendship during the last 2 weeks?**

1☐ I never need to depend on them. (51)

2☐ I usually did not need to depend on them.

3☐ About half the time I needed to depend on them.

4☐ Most of the time I depend on them.

5☐ I depend completely on them.

EVERYONE answer Questions 36 and 37, even if your relatives are not living.

36. **During the last two weeks, have you been thinking that you have let any of your relatives down or have been unfair to them at any time?**

1☐ I did not feel that I let them down at all. (54)

2☐ I usually did not feel that I let them down.

3☐ About half the time I felt that I let them down.

4☐ Most of the time I have felt that I let them down.

5☐ I always felt that I let them down.

37. **During the last two weeks, have you been thinking that any of your relatives have let you down or have been unfair to you at any time?**

1☐ I never felt that they let me down. (55)

2☐ I felt that they usually did not let me down.

3☐ About half the time I felt they let me down.

4☐ I usually have felt that they let me down.

5☐ I am very bitter that they let me down.

Are you living with your spouse or have been living with a person of the opposite sex in a permanent relationship?

1☐ YES, Please answer questions 38-46. (56)

2☐ NO, Go to question 47.

38. **Have you had open arguments with your partner in the last 2 weeks?**

1☐ We had no arguments and we got along well. (57)

2☐ We usually got along well but had minor arguments.

3☐ We had more than one argument.

4☐ We had many arguments.

5☐ We were constantly in arguments.

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FIGURE 26

A Social Adjustment Self-Report (Cont'd)

Study	Patient Number	Patient Initials	21 SAS-SR-Patient Page 5 of 6
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SOCIAL ADJUSTMENT SELF REPORT QUESTIONNAIRE (Page 5 of 6)

39. **Have you been able to talk about your feelings and problems with your partner during the last 2 weeks?** (58)

1☐ I could always talk freely about my feelings.
2☐ I usually could talk about my feelings.
3☐ About half the time I felt able to talk about my feelings.
4☐ I usually was not able to talk about my feelings.
5☐ I was never able to talk about my feelings.

40. **Have you been demanding to have your own way at home during the last 2 weeks?** (59)

1☐ I have not insisted on always having my own way.
2☐ I usually have not insisted on having my own way.
3☐ About half the time I insisted on having my own way.
4☐ I usually insisted on having my own way.
5☐ I always insisted on having my own way.

41. **Have you been bossed around by your partner these last 2 weeks?** (60)

1☐ Almost never.
2☐ Once in a while.
3☐ About half the time.
4☐ Most of the time.
5☐ Always.

42. **How many times have you and your partner had intercourse?** (63)

1☐ More than twice a week.
2☐ Once or twice a week.
3☐ Once every two weeks.
4☐ Less than once every two weeks but at least once in the last month.
5☐ Not at all in a month or longer.

45. **Have you had any problems during intercourse, such as pain these last two weeks?** (64)

1☐ None.
2☐ Once or twice.
3☐ About half the time.
4☐ Most of the time.
5☐ Always.
8☐ Not applicable; no intercourse in the last two weeks.

42. How much have you felt dependent on your partner the last 2 weeks? (61)

1 ☐ I was independent.
2 ☐ I was usually independent.
3 ☐ I was somewhat dependent.
4 ☐ I was usually dependent.
5 ☐ I depended on my partner for everything.

43. How have you felt about your partner during the last 2 weeks? (62)

1 ☐ I always felt affection.
2 ☐ I usually felt affection.
3 ☐ About half the time I felt dislike and half the time affection.
4 ☐ I usually felt dislike.
5 ☐ I always felt dislike.

48. How have you felt about intercourse during the last 2 weeks? (68)

1 ☐ I always enjoyed it.
2 ☐ I usually enjoyed it.
3 ☐ About half the time I did and half the time I did not enjoy it.
4 ☐ I usually did not enjoy it.
5 ☐ I never enjoyed it.

QUESTIONS 47-54 On Next Page.

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FIGURE 28

A Social Adjustment Self-Report (Cont'd)

Study	Patient Number				Patient Initials			21	SAS-SR-Patient	Page 6 of 6
									Depression Research Unit	

SOCIAL ADJUSTMENT SELF REPORT QUESTIONNAIRE (Page 6 of 6)

CHILDREN

Have you had unmarried children, stepchildren, or foster children living at home during the last two weeks?

1☐ YES, Answer questions 47-50. (66)
2☐ NO, Go to question 51.

47. Have you been interested in what your children are doing – school, play or hobbies during the last 2 weeks?

1☐ I was always interested and actively involved. (67)
2☐ I usually was interested and involved.
3☐ About half the time interested and half the time not interested.
4☐ I usually was disinterested.
5☐ I was always disinterested.

48. Have you been able to talk and listen to your children during the last 2 weeks? Include only children over the age of 2.

1☐ I always was able to communicate with them. (68)
2☐ I usually was able to communicate with them.
3☐ About half the time I could communicate.
4☐ I usually was not able to communicate.
5☐ I was completely unable to communicate.
8☐ Not applicable; no children over the age of 2.

FAMILY UNIT

Have you ever been married, ever lived with a person of the opposite sex, or ever had children? Please check

1☐ YES, Please answer questions 51-53. (71)
2☐ NO, Go to question 54.

51. Have you worried about your partner or any of your children without any reason during the last 2 weeks, even if you are not living together now?

1☐ I never worried. (72)
2☐ Once or twice I worried.
3☐ About half the time I worried.
4☐ Most of the time I worried.
5☐ I always worried.
8☐ Not applicable; partner and children not living.

52. During the last 2 weeks have you been thinking that you have let down your partner or any of your children at any time?

1☐ I did not feel I let them down at all. (73)
2☐ I usually did not feel that I let them down.
3☐ About half the time I felt I let them down.
4☐ Most of the time I have felt that I let them down.
5☐ I let them down completely.

49. How have you been getting along with the children during the last 2 weeks?

1☐ I had no arguments and got along very well. (69)
2☐ I usually got along well but had minor arguments.
3☐ I had more than one argument.
4☐ I had many arguments.
5☐ I was constantly in arguments.

50. How have you felt toward your children these last 2 weeks?

1☐ I always felt affection. (70)
2☐ I mostly felt affection.
3☐ About half the time I felt affection.
4☐ Most of the time I did not feel affection.
5☐ I never felt affection toward them.

53. During the last 2 weeks, have you been thinking that your partner or any of your children have let you down at any time?

1☐ I never felt that they let me down. (74)
2☐ I felt they usually did not let me down.
3☐ About half the time I felt they let me down.
4☐ I usually felt they let me down.
5☐ I feel bitter that they have let me down.

FINANCIAL – *EVERYONE PLEASE ANSWER QUESTION 54.*

54. Have you had enough money to take care of your own and your family's financial needs during the last 2 weeks?

1☐ I had enought money for needs. (75)
2☐ I usually had enough money with minor problems.
3☐ About half the time I did not have enough money but did not have to borrow money.
4☐ I usually did not have enough money and had to borrow from others.
5☐ I had great financial difficulty.

☐☐ VISIT ☐2☐1☐1 FORM CARD (76-80)

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FIGURE 27

The Client Episode Outcome Summary

CLIENT EPISODE OUTCOME SUMMARY
Side 1 — DEMOGRAPHIC DATA

CLIENT'S NAME (Optional)
(PRINT)

Last First Middle

CLIENT'S INITIALS 01 ☐☐☐ Last, First, Middle	**GROSS INCOME** 09 ☐☐☐☐ Use Income from UMDAP
BIRTHDATE AND AGE M M D D Y Y AGE 02 ☐☐☐☐☐☐ ☐☐	**CENSUS TRACT and/or HEALTH DIST. (Optional)** 10 ☐☐☐☐☐☐ and/or ☐☐☐
SEX 03 ☐ 1=Male 2=Female	**STATE USE ONLY** 11 ☐☐☐☐☐☐☐☐☐☐
RACE 04 ☐ 1=White, 2=Negro or Black, 3=Mexican-American, 4=American Indian, 5=Oriental, 6=Other Nonwhite	**COUNTY USE ONLY** 12 ☐☐☐☐☐☐☐☐☐☐☐☐
MARITAL STATUS 05 ☐ 1=Never Married, 2=Now Married, 3=Widowed, 4=Dissolved, 5=Separated, 6=Common law, 7=Unknown	**CASE NUMBER** 13 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
EDUCATION 06 ☐☐ Number of Years	**CR/DC PROVIDER NUMBER** 14 ☐☐☐☐
OCCUPATION 07 ☐☐ Enter Code From Occupation Key	**REPORTING UNIT** 15 ☐☐☐☐
EMPLOYMENT STATUS 08 ☐ 1=Full time, 2=Part time, 3=Unemployed, 4=Self-employed, 5=Unknown	**ENTRY DATE** M M D D Y Y 16 ☐☐☐☐☐☐

This 2-part form, a revision of a similar form used by the State of California Department of Health, is reprinted from Resource Materials for Community Mental Health Program Evaluation (Second Edition) edited by William A. Hargreaves, C. Clifford Attkisson, and James E. Sorensen. DHHS Publication No. (ADM) 79-238, 1979.

FIGURE 27: The Client Episode Outcome Summary (CONT'D)

CLOSING DATE

M M D D Y Y

17 ☐☐☐☐☐☐

REFERRED FROM

18 ☐☐ Use Codes from Referral Code List

REFERRED TO

19 ☐☐ Use Codes from Referral Code List

IF INVOLUNTARY ADMISSION W & I 5150

20 ☐ 1=Gravely Disabled 2=Danger to Self 3=Danger to Others

ALL LEGAL CLASSES DURING EPISODE

21 ☐☐ Add Applicable Binary Codes and Enter Sum

01=Voluntary
02=72hr. Detention
04=1st 14 Day Certification
08=Additional 14 Day Certification
16=90 Day Post Certification
32=Conservatorship—Temporary or Permanent

22- COSTS AND UNITS OF SERVICE

MODE OF SERVICE	COST CENTER	RATE (Round to Nearest $)	NUMBER OF UNITS
☐	☐☐	☐☐☐	☐☐☐
☐	☐☐	☐☐☐	☐☐☐
☐	☐☐	☐☐☐	☐☐☐
☐	☐☐	☐☐☐	☐☐☐
☐	☐☐	☐☐☐	☐☐☐

MODE OF SERVICE CODES

Inpatient..... 1
Partial Care..... 2

Outpatient
Assessment..... 3
Chemotherapy..... 4
Collateral..... 5
Individual..... 6
Group..... 7

SER 1434-A (6/74)

FIGURE 27: The Client Episode Outcome Summary (CONT'D)

CLIENT EPISODE OUTCOME SUMMARY
Side 2- SERVICES ASSESSMENT SUMMARY

"CONFIDENTIAL PATIENT/CLIENT INFORMATION
See California Welfare and
Institutions Code Section 5328"

INSTRUCTIONS

At Initial Contact:
COL A- Check all problems describing present impairment.
COL B- Check all problems which you intend to change. Circle the checkmark for the single problem which will be the primary focus of your effort, i.e., primary problem.
COL C- For each problem checked in Col. A, enter appropriate number from Problem Rating Scale.

At Final Contact:
COL D- For each column checked in Col. A, enter appropriate number from Problem Rating Scale.

PROBLEM RATING SCALE DEFINITIONS

The following definitions are to be used at initial and final contact in the rating of each problem checked in COL. A.

1 No impairment.

2 Minimal Impairment- symptoms present but no difficulty reported or observed in maintaining usual performance levels.

3 Mild Impairment- reported or observed difficulty in maintaining usual performance levels.

4 Moderate Impairment- reported or observed decrease in usual performance levels.

5 Severe Impairment- reported or observed failure in usual performance levels.

GLOBAL IMPAIRMENT INSTRUCTIONS

A. At initial contact, determine the overall rating of total impairment in daily functions and role requirements. Record the level number in table below (No. 1).

B. At final contact, rerate global impairment and record impairment level number in table below (No. 2). Check a or b as appropriate.

GLOBAL IMPAIRMENT SCALE DEFINITIONS

Overall rating of total impairment in daily functioning and role requirements...

1 No symptoms observable or reported.

2 Symptoms are very mild and observable or reported but no impairment in carrying out daily activities or in meeting role requirements.

3 Symptoms are mild and increased effort is required to maintain unimpaired level of functioning in daily activities and role requirements.

4 Symptoms are moderate and there is an observable loss of efficiency/effectiveness in meeting daily activity and role requirements (e.g. done poorly or incompletely).

5 Symptoms are moderately severe and client fails to meet one or two important roles such as work, school, housework, spouse, parent or in community, e.g., some activities not done at all.

6 Symptoms are severe and client fails to meet most role and performance requirements.

7 Symptoms are very severe and client fails to meet most or all role and performance requirements.

FIGURE 27: The Client Episode Outcome Summary (CONT'D)

COMMON PROBLEM DEFINITIONS	INITIAL CONTACT			Final Contact
	COL. A	COL. B	COL. C	COL. D
	All Impairment Probs.	All Probs. To Be Served	Ind. Prob. Rating	Ind. Prob. Rating
1. DEPRESSION- Reports of subjective feelings and concerns and psychosocial dysfunctions that may be associated with the depressive syndrome.	01	01	01	01
2. ANXIETY- Reports of subjective feelings and concerns, and psychophysiological dysfunctions that may be associated with the anxious, phobic, or obsessive-compulsive syndromes.	02	02	02	02
3. INAPPROPRIATE AFFECT, APPEARANCE, OR BEHAVIOR- Appearance, physical behavior or acts which would be considered odd or inappropriate by most untrained persons.	03	03	03	03
4. NEGATIVE-OBSTINANCY- Refusal to answer questions or cooperate; withholding information.	04	04	04	04
5. AGITATION-EXCITEMENT- Overt signs of agitation or excitement (e.g. inability to sit still, pacing, handwringing, accelerated speech, hyperactivity).	05	05	05	05
6. MOTOR RETARDATION-LACK OF EMOTION- Visible signs of retardation in speech and movement, a tendency to ignore the surroundings, and flattening of affect or general lack of emotional expression.	06	06	06	06
7. SPEECH DISORDERS- Impairment in the form or organization of speech (e.g. blocks, rambles, is incoherent, stutters, "Babytalks").	07	07	07	07
8. SUSPICION-PERSECUTION-HALLUCINATIONS- Distrustfulness; feelings of having been mistreated, taken advantage of, tricked or pushed around; ideas of reference; various paranoid delusions; auditory hallucinations which mock, threaten, or command.	08	08	08	08
9. GRANDIOSITY- Inflated appraisal of his worth, contacts, power, or knowledge; braggings; sensational plans; delusions of power, status, knowledge, or contact; and hallucinations with a grandiose connotation.	09	09	09	09
10. SUICIDE-SELF-MUTILATION- Suicidal thoughts, preoccupation, threats, gestures or attempts, and thoughts or acts of self-mutilation.	10	10	10	10
11. SOMATIC CONCERN-PHYSICAL PROBLEM- Real or imagined physical complaint or disability; conversion reaction; somatic delusion or hallucinations, hypochondriasis; or body image concern.	11	11	11	11

FIGURE 27: The Client Episode Outcome Summary (CONT'D)

12. DAILY ROUTINE-LEISURE TIME IMPAIRMENT- The impact of psychopathology on daily routine, on carrying through self-appointed or expected tasks, and on usual leisure time or recreational activities (e.g. difficulty in arising in the morning, getting dressed, and traveling).	12	12	12	12
13. REPORTED OVERT ANGER- Reported or observed overt anger or belligerence; shouting, temper tantrums.	13	13	13	12
14. DISORIENTATION-MEMORY IMPAIRMENT- Visible signs of disorientation as to time, place, and persons, and impairment of recent or remote memory.	14	14	14	14
15. SOCIAL ISOLATION- Lack of friends, avoidance of contact or involvement with others, and feelings of isolation, rejection, or discomfort with people.	15	15	15	15
16. MATURATIONAL PROBLEMS- Failure to achieve age appropriate interpersonal or family relationships; and/or age appropriate adaptive behavior (e.g., work, school).	16	16	16	16
17. DENIAL OF ILLNESS- The extent to which the patient denies, despite the evidence, that his current symptoms have psychiatric significance, that he is ill or needs psychiatric help, or that he needs to change his attitude in some specific way.	17	17	17	17
18. ANTISOCIAL OR ILLEGAL ACTS- Lying; stealing; swindling; conning; commission of or involvement in minor or serious illegal or delinquent acts.	18	18	18	18
19. ALCOHOL ABUSE- The degree to which the use of alcohol is excessive, compulsive, causes physical symptoms or alteration in mood or behavior, or interferes with performance of expected daily routine or duties.	19	19	19	19
20. DRUG ABUSE- Excessive self-medication and habituation or addiction to narcotics, barbiturates, stimulants, or consciousness-altering substances.	20	20	20	20
21. DANGER TO OTHERS- Has made serious threats of violence or actual assaults against other persons (violence against property not included); child abuse.	21	21	21	21
22. IMPULSE CONTROL- Lacks self-discipline; responses to stimuli exceed limits of expected behavior; responses to stimuli are without regard to consequences; or impulses to commit delinquent or illegal acts.	22	22	22	22
23. SEXUAL PROBLEMS- Sex role confusion; engages in sexual behavior which is defined as unacceptable by self, family, or society.	23	23	23	23

FIGURE 27: The Client Episode Outcome Summary (CONT'D)

24. PROLONGED EXPOSURE TO POOR ENVIRONMENTAL CONDITIONS- Such as long-term disturbed family relationships, chronic dysfunctioning or absence of a significant other; psychosocial deprivation.	24	24	24	24
25. SITUATIONAL CRISIS- A decrease in ability to cope with actual or threatened loss related to self-image, role mastery or relationship with a significant other.	25	25	25	25
26. HOUSEKEEPER ROLE- Admission of doing a poor job as a housekeeper, no pleasure or satisfaction in any aspect of household duties; marked discomfort or difficulty with, or refusal to carry out, one or more expected household tasks.	26	26	26	26
27. WAGE EARNER ROLE- No interest or satisfaction in one's job; dread of one's work; failure to meet task standards; need for constant supervision; psychopathology interferes with work; excessive job changes; or limiting oneself to part-time, temporary, or transient work because of psychopathology.	27	27	27	27
28. STUDENT OR TRAINEE ROLE- Poor motivation; avoidance of available extracurricular activities; missing classes; difficulty doing homework or assignments; poor grades; need for extensive help; or conflict with teachers or administration.	28	28	28	28
29. MATE ROLE-MARITAL PROBLEMS- Affectionate feelings rarely experienced or expressed; many quarrels; little or no sexual activity; few shared friends or social activities.	29	29	29	29
30. PARENT ROLE- Inability to carry out important child care tasks; requiring considerable help to manage child; morbid fears of child being injured or ill.	30	30	30	30

GLOBAL IMPAIRMENT

1. INITIAL RATING ..... ☐ a. Service Completed ☐

2. FINAL CONTACT ..... ☐ b. Apparent Dropout ☐

INTENT OF SERVICE

☐ Treatment ☐ Maintenance ☐ Evaluation Only

FINAL PRIMARY DIAGNOSIS
DSM-2 for M.I., AAMD for M.R. ☐☐☐☐☐

TARGET GROUP

☐ Mentally Disordered ☐ Drug Abuse ☐ Alcoholism

☐ Life Crisis ☐ Mentally Retarded ☐ Children & Adolescents

SER 1434-9 (5/74) Problem definitions adopted in part from Spitzer, R.L. Endicott, J., et al. The Psychiatric Status Schedule (1970). Arch Gen. Psychiat. 23,41-55.

CHAPTER SIX

IMPLEMENTING A QUALITY ASSURANCE SYSTEM

Chapter Six describes and defines the quality assurance cycle that remedies deficiencies in care identified through the methods described in Chapters One, Four, and Five. Appropriate educational and organizational interventions are examined and corrective plans formulated. Evaluation is stressed to assess the adequacy of the corrective program, and data development and in-depth policy analysis are described as steps in establishing organizational change.

KEY TOPICS

- The function of the quality assurance system
- The process of quality assurance (steps involved)
- Identifying deficiencies in individual, staff, unit, or program
- Organizing programs for staff education and career development
- Using data to change policy, structure, and procedure
- Establishing organizational priorities—fiscal incentives or legal imperatives
- Clarifying and modifying policy
- Examining and using service data in the context of organization policy
- The process of organizational change

CHAPTER SIX

IMPLEMENTING A QUALITY ASSURANCE SYSTEM

To the extent that peer and utilization review serve as catalysts for helping clinicians and organizations improve their services, they represent central elements of a quality assurance system. The most important function of such a system is to discover problems and deficiencies in the delivery of care and stimulate efforts to correct them. This chapter discusses general issues related to the quality assurance system and provides examples of both educational and organizational interventions that can be used to correct identified problems and deficiencies in the delivery of care.

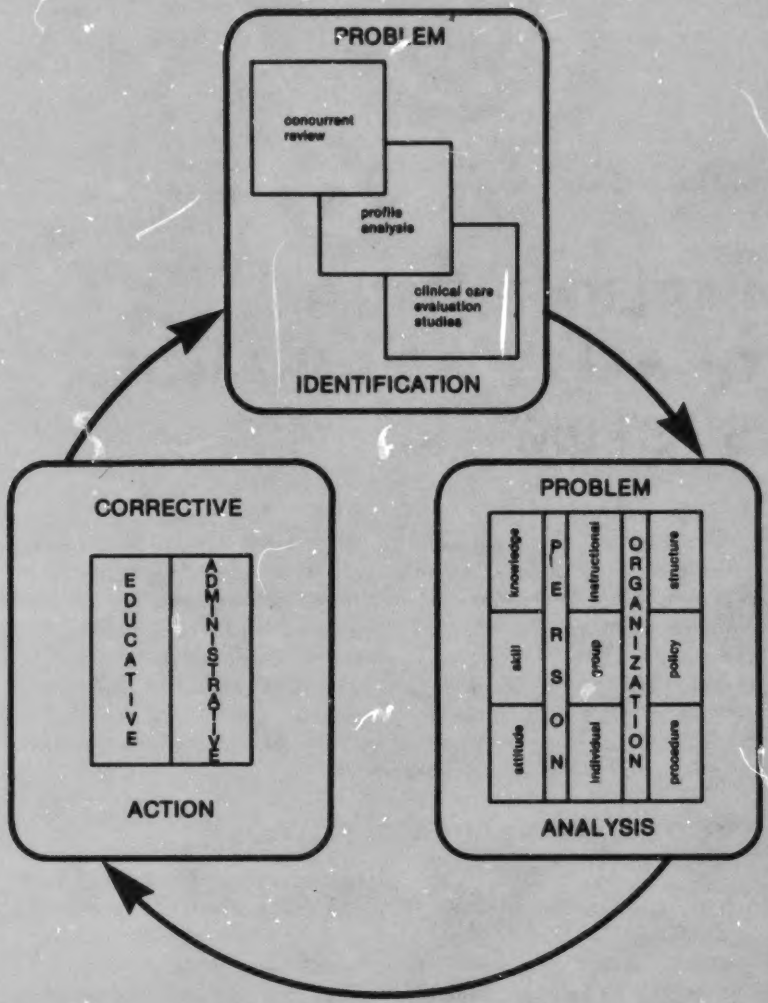
THE QUALITY ASSURANCE CYCLE

The process of discovering problems and deficiencies in the delivery of care and taking steps to correct them can best be schematized as a series of interrelated activities which comprise a quality assurance cycle. As shown in figure 28, the cycle begins with the identification of a problem and moves to the stage of problem analysis. Based on the analysis, a set of corrective activities is undertaken. The impact of these activities is then measured in the same manner used during the problem identification phase.

In the preceding chapters, the basic modalities for problem identification have been detailed, specifically concurrent review, profile

FIGURE 28

The Quality Assurance Cycle



analysis, and clinical care evaluation studies. The current discussion focuses on other elements of the quality assurance cycle—problem analysis, corrective action, and evaluation.

Analysis of problems and deficiencies in the delivery of care

Once identified, problems must be conceptualized in a manner that facilitates action. The conceptualization should take into account two factors: The *magnitude* and the *locus* of the problem. Specifying the magnitude—institutionwide, a particular unit, an identifiable staff group or discipline, or an individual practitioner—enables those responsible for quality assurance to project the extent of intervention required. Identifying the locus of a problem or deficiency, on the other hand, allows the quality assurance staff to formulate the required intervention based on whether the problem lies with a person or a program.

Deficiencies in personnel arise from three major sources: insufficient knowledge on the part of an individual, a lack of skills necessary for performing the required tasks, or staff attitudes in relation to the task at hand. For example, the inability of a staff member to meet the needs of persons with chronic mental disabilities for housing, food, and employment may reflect inadequate knowledge of the basic community support system—a deficiency of knowledge. A high dropout rate from group therapy may result from the use of group leaders with little or no training in the technique of group therapy—a deficiency of skill. A therapist's case load may be significantly less than that of his peers because he will only work with patients that are suitable candidates for a specific therapeutic modality (e.g., behavior therapy, long-term psychotherapy)—a deficiency of attitude. Each of these problems requires a different form of educational intervention.

Organizational issues may also be at the root of problems in the provision of care. Institutions may have deficiencies in program structure, program policy, or procedures. For example, an unusually high dropout rate of Hispanic patients as compared to other ethnic groups despite an adequate number of bilingual and bicultural staff might reflect the lack of an organizational focal point with clearly delegated responsibility for providing service to this population—a deficiency of structure. The method of assigning patients to clinicians in an outpatient clinic may delay placement sufficiently to cause large numbers of patients seen for evaluation to miss their initial treatment appointments—a deficiency of procedure. Finally, the mean stay of inpatients with a diagnosis of depression in one

ward may be 2 weeks longer than patients on another ward because somatic therapies are not initiated until a 14-day trial of verbal and milieu therapy is completed—a deficiency of policy. Once again, each of these problems requires a different form of intervention, but these interventions are administrative rather than educational.

It should be kept in mind that deficiencies of program may appear as deficiencies of personnel. Before deciding that a particular problem reflects a deficit in knowledge, skills, or attitude on the part of a clinician or group of clinicians, the evaluator should be certain that clinician performance does not reflect a latent organizational problem. For example, a clinical care evaluation study of inpatient care may reveal a marked delay in obtaining consultations when potential physical problems are identified. A case analysis shows that some clinicians promptly submit consultation requests, others submit these requests less promptly. If the analysis stopped here, one might conclude that the problem is one of person. But suppose that further analysis revealed a 3- to 4-day delay in answering consultations regardless of when they were submitted and a cumulative debt of $3,000 owed the consultant for prior services rendered. What appears to be a problem of person then emerges as one of organization or program.

Delineating actions for correcting the problem

Through analysis of a problem in terms of its magnitude and locus, the intervention required and the people who must be involved in a corrective plan can be determined. When the problem reflects a deficiency of knowledge or skills, the appropriate interventions are likely to be educational. When the deficiency is one of attitude or program, the appropriate intervention is likely to be either administrative or organizational. While issues of attitude may be handled through supervisory channels, those of program require changes in structure, policy, or procedure. One must identify whether the primary mode of intervention will be *educational, administrative,* or *organizational.* In the process, it is important to define the desired behavioral changes, educational goals, or system modifications required to deal with the problem. To the extent that goals are stated in measurable terms, the success or failure of the corrective plan can be determined objectively. This is not always possible; however, the corrective plan should specify the manner in which the impact of the intervention will be evaluated. A more detailed description of potential educational and organizational interventions is provided later in this chapter.

Evaluating the impact of actions taken

The final step in the quality assurance cycle involves evaluating the effects of the corrective plan that has been initiated. At a minimum, the process will include a replication of the steps taken to originally identify the problem and a reanalysis of the data to determine the extent to which the objectives have been achieved. Usually, considerable reliance will be placed on the methods used during the problem identification phase of the cycle to generate these data, including concurrent review, profile analysis, and clinical care evaluation studies. Until the assessment of impact has been made, this process is a quality assessment cycle, not a quality assurance cycle. The assurance is achieved through closing the feedback loop by assessing the adequacy of the corrective program.

EDUCATIONAL INTERVENTIONS

In thinking about the educational needs of staff working within a mental health organization, it is useful to distinguish between efforts directed at:

1. Insuring adequate baseline knowledge and skills for staff to perform the service tasks for which they have been hired
2. Advancing individuals to higher levels of knowledge and expertise
3. Correcting performance deficits detected as a result of supervisory, peer review, or program evaluation activities.

These different objectives provide a format for organizing a staff education program. The elements of such a program would include: educational assessment during entry-level training, continued education and career development, and performance evaluation and supplemental instruction.

Educational assessment and entry-level training

In the recruitment of staff to work in a mental health setting, attention is generally paid to a host of factors that, it is hoped, will predict an applicant's ability to make a substantive contribution to the program's service mission. The factors include not only educational background and prior training in the mental health field, but other issues such as psychological sensitivity, ethnic background, knowledge of the community being served, and limitations imposed

by budget on potential salary levels. Indeed, for certain lower-level positions, only minimal knowledge of the mental health field may be required, other factors weighing more heavily in the decision to hire. Once an applicant has been hired, however, the organization has a clear responsibility to assess training needs and to ensure that new employees are able to gain the requisite skills and knowledge necessary to effectively perform the tasks for which they were hired. It is one thing to consider multiple criteria in the selection of employees and quite another to assure that employees can function effectively on the job.

To meet this organizational responsibility, an educational assessment should be an integral part of the recruitment process. Such an assessment would take into account the range of backgrounds of employees and identify areas of educational need. The term "educational need" refers to a new employee's need for both knowledge and skills. Many needs can be met through supervised on-the-job training. In some instances, more formal didactic methods will be required (e.g., seminars on the nature of mental health and illness, teaching exercises geared to developing skills as an evaluator, or tutorials in selected areas of patient management). An institution may undertake these educational tasks independently, or, if this is not possible, educational opportunities could be made available to staff through a combination of release time and/or arrangements with educational facilities within the community.

When a program of entry-level training exists, it is important to realize that the staff involved are employees, not full-time students. An educational program which compromises the ability of service units to function at a reasonable capacity is unlikely to generate support from persons with programmatic responsibilities. For that reason, departmental heads, unit chiefs, and the like should be involved in developing the educational assessment and entry-level training program.

Continued education and career development

It is important to distinguish between educational programs intended to advance staff members to higher levels of knowledge and expertise in their specialized fields and training programs to help personnel perform their service tasks better. The latter training, which may be highly specific and task-oriented, is most appropriately regarded as inservice training. The responsibility for developing and implementing inservice training should be assigned to particular service units. For example, instruction concerning the psychological management of acutely suicidal patients can best be

taught on an inpatient or emergency service, whereas a course on defense mechanisms could be offered on an ambulatory service or clinical unit. Since needs of service units often overlap, provision should also be made for cross-listing various inservice exercises to ensure access for appropriate nonunit staff members as required.

Programs which allow individuals to build on and expand their skills so that they may advance to a higher level of knowledge and expertise relate primarily to career development and ideally should provide some tangible acknowledgement of professional growth such as a certificate or degree. They are often sponsored by professional organizations or educational institutions, so many of these activities are extramural and staff participation occurs on a personal time. Whenever possible, however, service institutions should offer credit for its seminars and other educational activities. Because this requires some coordination between the service program and the educational institution or professional association, a locus of responsibility for inservice and continuing education activities should be designated within the organization (e.g., a training unit in a CMHC or a nursing department in a hospital).

Performance evaluation and supplemental instruction

Evaluation of individual staff member performance is generally a shared responsibility. Program managers, service chiefs, discipline heads, and the peer and utilization review personnel all play a role in the evaluative process. Through service ratings, case review, and special studies, it is possible to identify problems in the delivery of services that require supplemental staff education.

Supplemental educational programs may be either tutorial/supervisory or instructional. In mental health settings increased supervision is commonly used to correct skill deficits, and tutorial/preceptorships to correct knowledge deficits. Instructional programs range from unsupervised self-instruction through the use of programmed texts to enrollment in conventional didactic courses and seminars developed to address known skill or knowledge deficits. When practical, programs of supplemental instruction should be conducted at the institution or in the community where the clinician works.

Participation in the quality assurance program can itself be of great educational value. Clinical care evaluation studies and profile analyses frequently identify unsuspected problems. When these studies are conducted at a local level, peer pressure can exert a strong force for behavioral change. Increasing awareness of problems in clinical care is often a vital first step towards problem solv-

ing. The systematic examination of patterns of practice and the review of current clinical opinions in order to develop criteria and standards are also of educational value. This activity has the added advantage of making practitioners aware of the dichotomy between what they do and what they agree they should be doing. Participation in the development of objective measures assaying the quality of care can lead to self-evaluation of individual patterns of practice. This in turn can produce important changes in attitude and behavior that profoundly influence the quality of clinical care.

Implicit in the educational interventions discussed is the assumption that shortcomings in the delivery of care are due, in part, to inadequate knowledge and skills. A corollary of this assumption is that better information will change clinician behavior and thereby improve the process and outcome of care. Neither the assumption nor its corollary has been proven. That clinicians lack all sorts of information can be easily shown. What clinicians do with specific kinds of information, however, is poorly understood. What role information and education have in altering behavior, how behavioral changes come about, and what significance these have for patient management are questions which remain unanswered. Nor do we know if there are critical times in a clinician's development when information input may be ineffectual in modifying behavior. Thus, it is extremely important to continually evaluate the impact of educational interventions and not to assume that they are effective.

ORGANIZATIONAL INTERVENTIONS: USING DATA TO CHANGE POLICY, STRUCTURE, AND PROCEDURE

When considering organizational changes to enhance the quality of care, practitioners must keep in mind the overall functioning of the facility. Every organization must depend on its administrators to direct its activities, maintain and modify organizational structure, allocate resources in response to needs and the changing relationship to the environment, and anticipate and plan for the future. Administrators of mental health programs must balance requests for change with the need to preserve a degree of stability through the judicious manipulation of program policy, procedure, and structure. To accomplish this, they need data such as: Who is being served? How served? By whom? How efficiently? With what result and at what cost? These data are used not only to monitor the work of the organization, but also as feedback to change expectations, enhance organizational performance, and move the organization toward new tasks as they arise. Staff often lose sight of the impor-

tance of data in attaining their articulated goals. Too frequently they see only the monitoring aspects and view the evaluative needs of administration as a variation of the "big brother is watching you" theme. Administrators need to educate staff to the value of program self-examination as a vehicle for measuring excellence and assuring continuity and growth.

Generating data is relatively easy. Using it effectively, however, depends on the ability to ask meaningful questions. An administrator is well advised to begin by identifying the organization's responsibilities and priorities. Given the usual limited funding, multiple goals of equal weight lead to administrative nightmares. Assigning equal importance to all tasks fosters generalized mediocrity and low organizational morale. On the other hand, emphasizing one task at the expense of others can throw an organization into imbalance, where good performance in one area leads to poor performance in others. Only a clear sense of an organization's responsibilities and priorities can guide an administrator through this particular Scylla and Charybdis.

Some of the questions that must be asked are dictated by the source of program funding. Federally funded community mental health centers, for example, must answer a set of questions concerning who is served: Do poor people and members of minority groups have access to care? Are older people, children, addicts, and alcoholics served? When data demonstrate failure to comply, procedural or structural changes in program may be required. Other questions may be generated by the interaction between program and community groups, by cash-flow problems, or by deficiencies identified through the utilization review process. Here, too, analysis of the problem may suggest changes in organizational policy, procedures, or structure.

Clarifying or modifying policy

Unless new funds accompany the promulgation of new policy or an organization is able to reorganize to accomplish more with less, changes in policy tend to emphasize new tasks at the expense of old ones. In bureaucratic structures multiple constraints effectively limit the capacity for change, and the reorganizational ideal of doing more with less is rarely realized. The weight of laws and regulations, civil service or other labor/management guidelines, and hierarchical and multiple administrative structures, together with a separate planning structure, all conspire to make program managers feel that trying to accomplish more within their fixed resources is akin to swimming in shark-infested custard. Conversely, tying some priorities and not others to fiscal incentives can forcefully establish pol-

icy. Willie Sutton's law prevails. When asked why he robbed banks, he replied that he "went where the money is." Put in the language of the administrator: "Show me which way the wind is blowing on the money tree and I'll show you my priorities and policies."

In general, changes or clarification of policy precede changes in procedures, structures, technology, and individual behaviors. However, change in any of these areas can inadvertently or even deliberately lead to major modifications in institutional policy and priorities. In other words, changed structures or changed technology can also lead to changed policy. For example, today in our general hospitals an impressive new technology, computerized axial tomography (CAT), has led to new structures, demands for new resources, and, when funds were limited, to reallocation of and diminution of some old services; thus—new policy.

With these caveats in mind, it can still be argued that the first step in the redefinition of policy, or in reordering structures to better accomplish policy, is the collection and analysis of data. Mental health centers, drug and alcohol programs, and State-sponsored community clinics are required to collect data to show their compliance with policy mandates. Indeed, the development of quality assurance systems and the emphasis on creating organizational structures to evaluate mental health programs reflect policy decisions. Since resources are usually limited, evaluative activities tend to be restricted to those areas which affect the funding base. Patient-care evaluations are being emphasized because the costs can be built into the charges, and this type of evaluation is increasingly being mandated. Assessment of nontreatment activities (education, prevention, consultation) is accorded a secondary or tertiary priority because of both funding constraints and difficulties in criteria development.

An example of using data to change policy and structure

When the Connecticut Mental Health Center opened in July 1966, it expected to admit approximately 1,200 patients a year. In its first year 1,800 patients were served, and extensive waiting lists developed. In the second year, 2,400 patients were served. Staff insisted that more personnel were required to meet pressing clinical needs. They felt harassed, overworked, and overburdened. Institutional policy mandated that all who applied for care must be served, but the Center could find no new resources. A staff committee was charged with reviewing existing organizational structures and recommending appropriate change. The characteristics of applicants and patients were also studied.

It was discovered that the modal social class of patients in treatment was lower middle class—patients who often had referring physicians or spokesmen within the community. Although referred in large numbers, poor patients, Blacks, and Puerto Ricans were under-represented. No regulations required the Center to specifically treat the poor and underserved, but Center leadership insisted upon such service as *policy*. In the middle of the study year a waiting list was established that excluded almost all but emergency cases from care. Once again, 2,400 individuals were served.

The committee recommended structural changes. An entry system was proposed for the Center that would evaluate all new applicants for service, provide brief treatment for large numbers of them, and, when appropriate, refer them for service to other treatment units. Establishing an entry system underscored a policy decision to serve the poor and significantly increase their representation in Center treatment programs. Since no new resources could be allocated for the reorganization, existing programs were examined to determine how staff might be redeployed for such an intake service. Thus, the data base required for decisionmaking now contained information about institutional resources and structures.

At that time the Center had a free-standing day hospital which was the only resource available for continuing treatment of chronic psychiatric patients within the Center. This unit treated approximately 100 patients a year in an intensive group-oriented program. When it became clear that Center administration was committed to the development of an intake unit, senior clinical leadership decided to close the day hospital as an independent service, begin limited day hospital programs on the inpatient units using staff already in place on those units, and prepare the day hospital staff for reassignment during a 6-month period. Half the personnel were then assigned to an entry unit; the other half were assigned to a continuing-care service established to deal flexibly with the chronic patient population through medication clinics, socialization and rehabilitation activities, and a variety of group therapies. Approximately 80 of the patients previously treated in the day hospital could be managed within the community by this new service. Following this reorganization and the addition of a drug dependency program, the number of patients served by the Center rose dramatically to 3,600 in its fourth year of operation. The number of chronic patients maintained in the continuing-care service climbed to approximately 250 and is now over 750.

The example demonstrates how an examination of data and a careful consideration of alternative resource allocation permitted a program to vastly extend its services without expanding its

resources and without significantly diminishing the treatment modalities available to patients.

The steps included:

1. The development of *data* which demonstrated areas of service deficiency (similar to a profile analysis);
2. Commitment by administration to a *policy* of adequately serving those presenting for care;
3. Examination of available *resources* (no new resource available, re-examination of existing resources);
4. Establishment of a *process* which included relevant individuals in the decisionmaking process (involving senior clinical managers in the process led to organizational changes and to early communication with affected staff about proposed changes and the rationale for change);
5. Development of a *change strategy* (no staff would lose jobs; staff would be adequately retrained for new responsibilities and carefully supervised for some period of time in those new responsibilities); and
6. Continual *reassessment* of organizational changes and feedback to the organization.

Important tools, in effecting change were the clear articulation of generally accepted values and redefinition of value hierarchies. To deal with the concern that increasing work load would lead to less intensive and less "good" care, management insisted that equity of access and equality of service had highest priority. The Center's responsibility to surrounding community was emphasized and reemphasized. In addition, management insisted that a more effective entry system would lead to better utilization of therapy time and, thus, to fewer drop-outs.

Following the organizational change, the feedback showed a dramatic increase in the number of individuals utilizing services. At the same time, a significant change in the demographic characteristics of clients demonstrated that services were far more accessible to members of poor and minority groups.

A second example

Several years later, review data and comments from Hispanic community leaders made it quite clear that the Center was not serving the area's Puerto Rican population. Some insisted that Spanish-speaking individuals underutilized traditional medical and psychiatric resources, preferring "native healers." Utilization records of a local neighborhood health center were examined and showed unequivocally that Spanish-speaking individuals actively seek medical and even psychiatric services when offered by a health center and delivered by Spanish-speaking professionals.

Based on these findings, the Center decided to change its organizational structure. In discussions with community groups, a commitment was made to recruit a Spanish-speaking psychiatrist to head a special Spanish Clinic that would be part of the Center's intake and assessment services. Since the number of individuals who might use such a clinic was unknown, several staff positions within the intake and assessment service were allocated for new bilingual and bicultural staff who would be assigned part-time to the Clinic. It was explicitly stated that the new recruits were to spend as much time in the clinic as the workload warranted.

Again, the elements were similar: data evidencing need, affirmation of policy, commitment of administration, analysis of resource availability and appropriate reallocation of resources, involvement of senior clinical management, clarification of value hierarchies (equity), and, during the implementation phase, allocation of positions to the new clinic. Finally, the process of organizational change was monitored and frequently re-evaluated. Once again the organizational change was effective, and the numbers of Hispanic patients using services dramatically increased.

Changing organizational procedures

While structural changes are most dramatic, changes in procedure or in individual practices may be of even greater import to an organization and its clients. Procedures may be changed by intervention at multiple levels within the system. The changes themselves may result from concurrent or retrospective review activities. A clinical care evaluation study, by exploring a range of therapeutic and diagnostic activities, can identify unit or institutional deficiencies calling for important procedural changes. CCE studies on topics such as medication practices (e.g., which outpatients receive prescriptions for minor tranquilizers over many months, which ones are on high doses of medication, etc.) or compliance or noncompliance with therapeutic recommendations can

highlight areas needing better institutional procedures (e.g., recommendations as to prescription practices, polypharmacy), or the use of various discharge categories.

In one CMHC setting, a series of clinical care evaluation studies of Center patients transferred to State hospitals and State hospital patients referred for aftercare to the Center revealed major gaps in continuity of care. Analysis of the study results led to several programmatic changes. A special liaison team was established to facilitate transfer of patients. Within the Center, staff responsible for the patients' aftercare were assigned part-time to the Center's emergency service because the data showed that the index population not only tended to use both the emergency and chronic care services extensively, but were more likely to be hospitalized when seeking crisis care from the emergency service.

The organizational changes reduced hospitalization of these patients, improved liaison between services and institutions, and enhanced continuity of care. Followup studies, however, identified major problems in record retrieval. Only 20 percent of the patients discharged from the State hospital had hospital summaries noted in Center charts. Specific procedures were developed by both institutions collaboratively, and record-sharing dramatically increased.

Even when structural change has been accomplished, careful attention should be paid to procedural issues to assure quality care. As in other aspects of the quality assurance cycle, work is not complete without a followup restudy of the change procedure.

CONCLUSION

Priorities for review are established in the same manner as priorities for service. Mandated reviews must have precedence; reviews of problem areas ought to have precedence. While profile analyses, clinical care evaluation studies, and concurrent review provide impetus for change, the organization's administrator should not be bound by the inherent limitations in such studies. It is important to remember that numbers can be used to justify dramatically opposite policies. When used within a clearly defined policy context, however, review data can effectively demonstrate how a policy is being implemented. The power of the data though is not in the numbers but in the use of the numbers to underscore a moral imperative: "We are not doing as we ought. We have responsibilities that are unmet and that transcend other values." To some extent the capacity of an organization to change reflects current internal and external political realities, and data are of value in that context or in changing that context.

Evaluation in and of itself has an impact upon the organization. It sensitizes practitioners to the necessity for review. It establishes "limits," identifying expectations as to practice. Patterns of care tend to become more routinized and individual differences limited. The danger, of course, is that meaningful innovation will become impossible and that the art of care—a humane, dignified approach to the patient—will be a casualty of increasing bureaucratization.

Organizational reviews are to a large extent constrained by the available data and the capacity to organize that data. So far, much of the work in mental health care is poorly quantified. The model described here uses data to change structures and procedures and has important checks built into it. It acknowledges the importance of policy and examines data within the context of policy and practice. It attempts to involve relevant individuals in the process of organizational change and highlights the importance of change strategies which attend to both patient and staff needs.

CHAPTER SEVEN

THE ORGANIZATIONAL CONTEXT OF QUALITY ASSURANCE

Chapter Seven discusses considerations in locating the responsibility for quality assurance activities within the CMHC by (1) presenting a general theory of the structure of the organization, the nature of tasks, and assignment of priorities for task accomplishments; (2) defining authority relationships and specialized role functions; and (3) reviewing organizational placement and management of a utilization review committee and the resources required for its proper operation.

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KEY TOPICS

- Primary task
- Boundary relationships
  - Entry, transformation, and export
- Center management
  - Administrative regulatory functions
  - Skill pools
  - Committees
- Organizational implications for review of care
  - The hospital and the organized quasi-independent medical staff
- Centralized and decentralized CMHCs and organizationally contained professional and/or medical staffs

CHAPTER SEVEN

THE ORGANIZATIONAL CONTEXT OF QUALITY ASSURANCE

In order to know where to locate quality assurance activities in an institution, we first need to understand something about the nature of organizations. For example, a series of questions might be asked about an organization:

What are the tasks of an organization?

How are priorities assigned?

How are the parts of the organization identified; how are they managed; how do they relate to each other?

How are decisions made?

What is the nature of the organization's transactions with its various environments?

How are organizational/environmental transactions managed?

Do different occupational groups within the organization have roughly equal influence, or do some possess greater authority and/or autonomy?

What are the consequences for task accomplishment of locating quality assurance structures in differing sectors of the organization?

All organizations have implicit or, more often, explicit definitions of authority relationships and specialized roles in regard to task performance. Thus, examining an organization's structure should reveal its tasks, its task priorities, and its image of the appropriate way of ordering work relationships.

A number of conceptual frameworks are available to describe organizational structure and function. Most managers are familiar with the Christmas tree approach to schematizing organizations which identifies line and staff functions separately. The authors' experience, however, suggests that the system evolved by A. K. Rice and Eric Miller (Rice 1963; Miller and Rice 1967) has particular value for medical, psychiatric, and psychological treatment facilities.

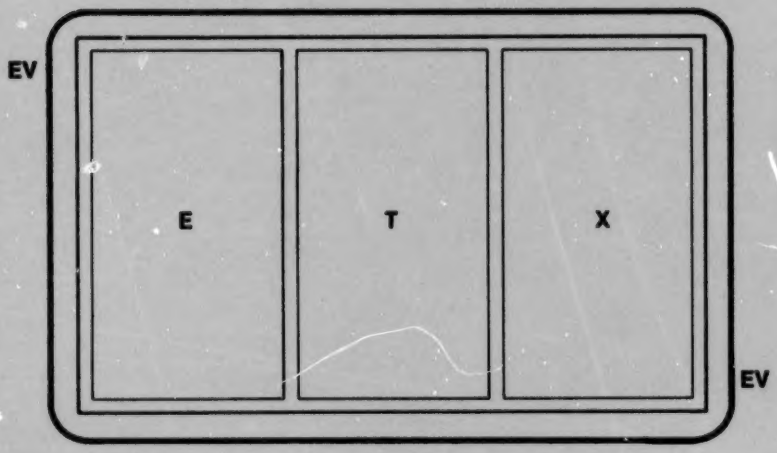
Rice and Miller stated that, if the structure of any organization is examined, its *primary task*—the one task that an organization must accomplish in order to survive—could be identified. This method would accurately identify primary tasks for the organization as a whole and for its subsectors. In other words, by looking at the organization of tasks and the way authority is defined and boundaries managed, the purposes of the organization would be clarified or, alternatively, confusion about goals would be made evident. Building on this concept, the authors have developed a framework for examining problems within psychiatric and psychological treatment settings.

THE ANALYTIC FRAMEWORK

In this framework, the organization is an open system. Open systems constantly interact with their environments. They consist of three major subsections: *entry*, *transformation*, and *export* (see figure 29). The *entry* subsystem is responsible for bringing appropriate supplies into the system at appropriate rates, as efficiently as possible. The supplies are altered within the organization—materials are utilized and products are made or, as in the context of mental health organizations, services are provided—by the *transformation* subsystem. Finally, the new product—or changed person—is exported by the *export* subsystem to the environment. The process generates new resources which enable the organization to continue the process.

FIGURE 29

The Organization as an Open System



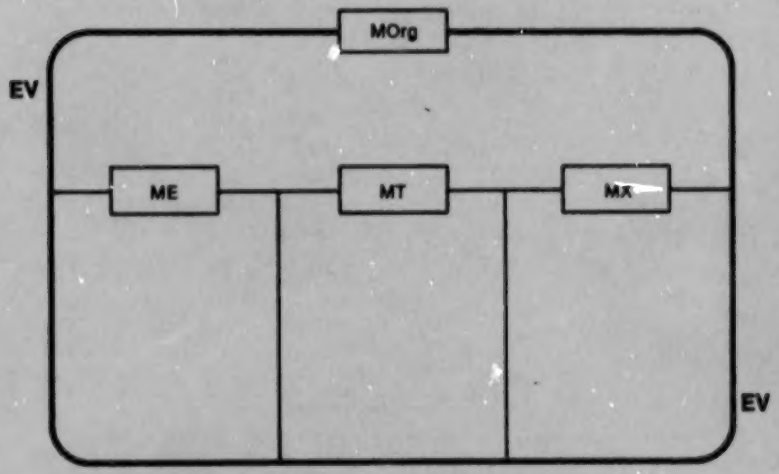
EV—Environment
E —Entry Subsystem
T —Transformation Subsystem
X —Export Subsystem

Boundary Relationships

Figure 30 shows the internal and external boundary relationships. The entire organization is separated from its environment, and its subsystems are separated from each other and from the managerial function that relates the organization as a whole to its environment. The diagram depicts a boundary as a *region of transaction;* transactions occur between the organization and its environment and among the subsystems. A major managerial task lies in regulating these transactions to preserve organizational integrity and vitality. Managers must ensure that the organization is not flooded by entries from the environment or that one subsystem is not flooded by entries from another. Maintaining organizational vitality means ensuring that the entry, transformation, and export of material or people by the organization occur at a rate sufficient to keep it from entropy and de-differentiation. Thus, the organizational boundary is not a barrier, but a carefully managed region of exchange.

FIGURE 30

Boundary Management Functions



MOrg—Management of the Organization
ME —Management of Entry
MT —Management of Transformation
MX —Management of Export

Rice's focus on primary task permits us to schematize an organization by first seeing where the boundaries are placed. Since the structure of the organization ideally serves its primary task, the boundaries should maximize accomplishment of the work the organization is set up to do.

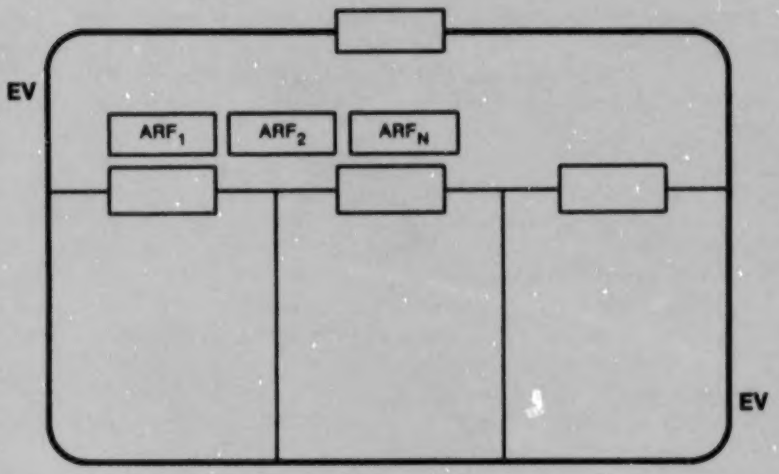
Administrative Regulatory Structures

Rice uses rectangles to identify managerial functions. The convention avoids the necessity of drawing boundaries within boundaries (see figure 31) and shows clearly that the role of organizational management is to (1) relate the entire organization to its environments and (2) manage the interaction of the parts of the organization.

The relatively simple structure becomes more complex when we attempt to locate the administrative functions within the organization. Administration is not identified as a line function within the

FIGURE 31

Administrative Regulatory Functions (Control)



ARF_1—Control Function...e.g. Personnel
ARF_2—Control Function...e.g. Budget
ARF_N—All Other Control Functions

organization, as, for example, another branch in a more traditional organizational diagram. Rather, administrative activities—budget, personnel, plant operations, and the like—are regarded as a set of functions which serve to *regulate* work. Traditionally, these functions are under the direct control of the executive function of the organization and are critically important to the successful accomplishment of managerial tasks. These functions are not located in any major activity area (i.e., entry, transformation, export) since they assist management in regulating the internal environment of the total organization, in planning, and in monitoring work. As an example, budgetary functions and personnel activities affect all the line units within the organization and are therefore placed to show their role in the total organization.

Skill pools

The organization must appropriately deploy its human resources. One way of conceptualizing this is to consider individuals as

members of identified *skill pools*, schematically represented by circles (see figure 32).

Within the organization, individuals are differentiated by skill level, training, status, and salary, but their needs also influence organizational structures. Their loyalties and commitments to subgroups, colleagues, etc., may be as important as commitment to work, perhaps even more important. To help in conceptualizing these issues, individuals are first identified by membership in certain "skill pools."*

Individuals from one skill pool may work in a number of different organizational structures. For example, one social worker may function in an entry structure in a mental health facility, performing intake functions. Another social worker might be primarily engaged in a specific transformation function—such as family therapy. A third might be working primarily in an export function, managing liaison with community agencies which receive discharged clients.

Individuals may be pulled by diverse and sometimes conflicting claims upon their personal commitment—to work groups, organizational subunits, skill pools, or professional associations, for example. Although the primary commitment might be to their unit or their discipline, their commitment to task (undertaken primarily through the unit) might at times be compromised by disciplinary issues (e.g., status of disciplinary group, as reflected by the authority of a disciplinary chief).

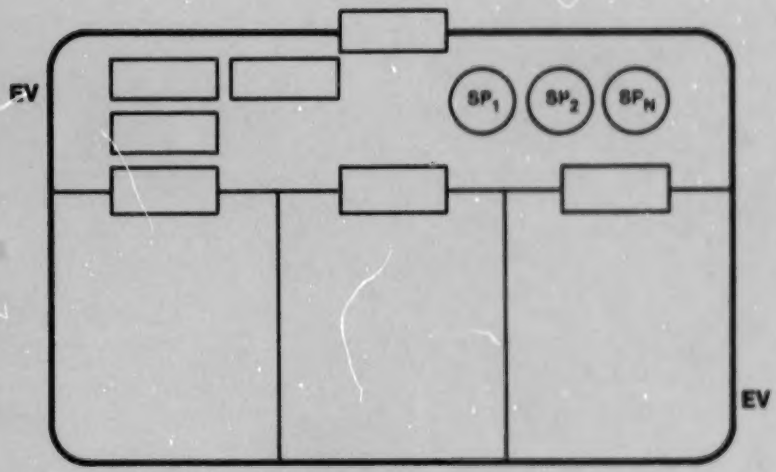
To avoid these conflicts in their staffs, subunit managers may routinely set up task boundaries to encompass areas of personal commitment also, thus discouraging individual staff members from engaging in extraunit activities or developing extraunit loyalties. Though this expedient often builds excellent intragroup working relationships, it may impair the accomplishment of required work if group norms regarding interpersonal behaviors assume priority over task accomplishment. Locating task and loyalty boundaries together may further lead to isolation of a unit, may be a powerful impediment to changing structure or goals, and may lead to group demoralization if major leadership figures leave.

From an organizational perspective, skill pools should be regarded as a staff function under the direct control of the chief executive. Designating an organizational base for a disciplinary group confirms the legitimacy of disciplinary identification. It also allows disciplinary skills to be emphasized, and continuing education needs

*Rice and Miller (1967) as well as Rice (1963) used the concept of sentience to describe the personal and group needs of individuals. Edelson (1970) preferred the term "skill pool" to show that the organization is interested in these areas of individual and member needs in order to structure them in the service of task accomplishment.

FIGURE 32

Skill Pools



SP_1 —Skill Pool . . . e.g. Physicians
SP_2 —Skill Pool . . . e.g. Nurses
SP_N —All Other Skill Pools

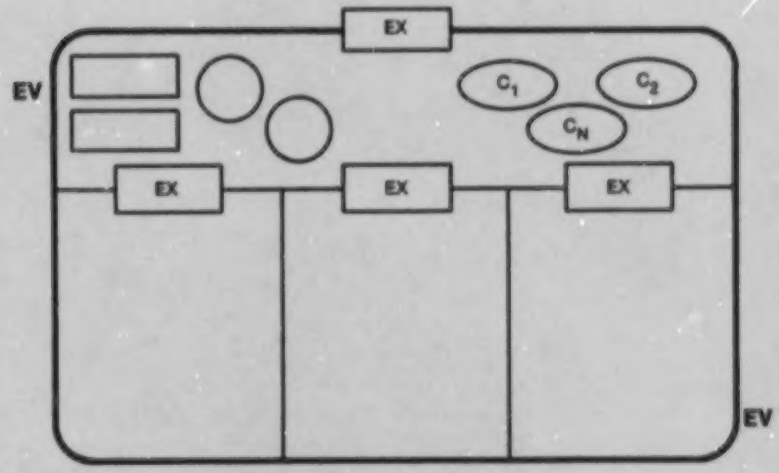
to be identified. It further facilitates consultation for operating units about the education, skills, and potential of discipline members. In addition, organizing by discipline helps to coordinate recruitment and to identify qualifications for promotion (within a specific framework). The disciplinary group should not compete for line authority with organizational units. Such competition subjects individuals to the conflicts of multiple subordination (Henry 1954) and interferes with the ability of the organization to accomplish its work.

Committee Structures

To complete the organizational framework, committees are developed to relate organizational activities, regulatory functions, and skill pools to each other. Thus committees engage in *intergroup activities*, arguing and compromising diverse positions and priorities. Committee structures are depicted on the organization chart as ovals (see figure 33). Committees can be viewed as ex-

FIGURE 33

Committee Structures



C_1—Committee...e.g. Utilization Review
C_2—Committee...e.g. Safety
C_N—All Other Committees
EX—Executive Group

tremely frustrating and the loci of organizational confusion if members misunderstand their tasks and influence. While committees may be charged with exploring significant issues and monitoring organizational activities, their authority devolves from the organization's administration. They assist management in problem-solving by reflecting and seeking to meld together a wide range of expert opinions. Committee appointments generally are initiated or confirmed by executive action. Staff support is assigned administratively. Committee decisions must be implemented through organizational administrative channels. Effective committees usually have the majority of their actions confirmed, although administrations have rejected even well-considered committee recommendations.

Committees are not management groups. Management groups, e.g., executive groups, have decisionmaking responsibilities and are clearly part of an organization's formal hierarchical structure. The executive constellation (Hodgson, Levinson, and Zaleznik 1965) is shown in figure 33 by the symbol "EX." Committee or skill-pool

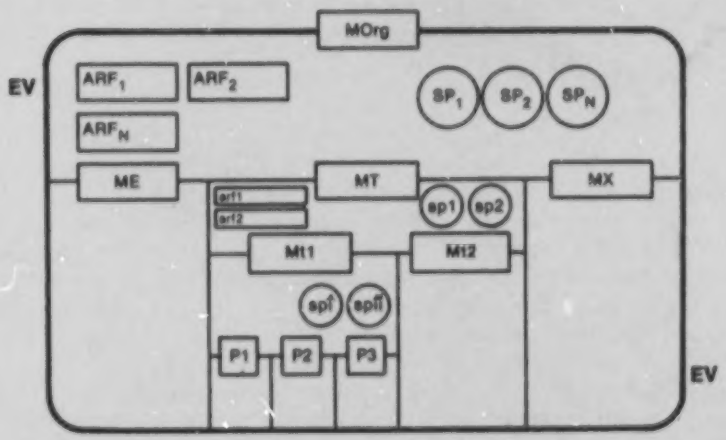
representatives and other administrative staff report to the executive group. In other words, the committee's role is advisory. A committee may problem-solve and recommend, but for action to be taken executive approval must be obtained.

A More Complex Organization

Most organizations are far more complex than those described so far. Figure 34 schematically presents a more complex organization with two major components in the transformation function. These might represent two manufacturing plants, or two major technologies within one plant. In a CMHC, the two components of the transformation function might be clinical services and consultation/education services. Each area could be further subdivided into operational units (i.e., clinical services can be subdivided into am-

FIGURE 34

A More Complex Organization



ARF1; ARF2 — Regulatory Functions limited to Transformation subsystem
sp1; sp2 — Skill Pool Functions limited to Transformation subsystem
Mt1; Mt2 — Management of Transformation subunits 1 and 2
spf; spff — Skill Pool Functions limited to Transformation subunit 1
P1; P2; P3 — Management of Projects (on smaller units) 1;2;3 in Transformation subunit 1

bulatory care, partial hospitalization, inpatient services, emergency services, etc.).

Regulatory and skill-pool functions must be located at the appropriate level of the organization. This means that, depending on organizational size and complexity, some of these functions may be found at several organizational levels. For example, a manufacturing corporation might need to assign some engineers to multiple sectors of the organization. Thus engineers in SP_1 might recruit engineers for the corporation and develop skills in young engineers by assigning them to several areas within the corporation. Other engineers may work in manufacturing and would thus be located in skill sp_1 which supplies engineers to both manufacturing plants (or subunits). Other engineers with very specialized skills might be located in only a particular plant (sp_i) or even a particular unit of that plant.

Similarly, social workers in SP_1 might be recruited for work in programs throughout the entire facility--in entry, transformation, and export areas. Conceivably psychologists might be employed only in transformation functions either as clinical therapists or as consultation/education specialists. Their disciplinary skill pool would be located at sp_1. Recreation therapists might be located in only one section of the transformation area, and their skill-pool location might be sp_i.

APPLICATIONS

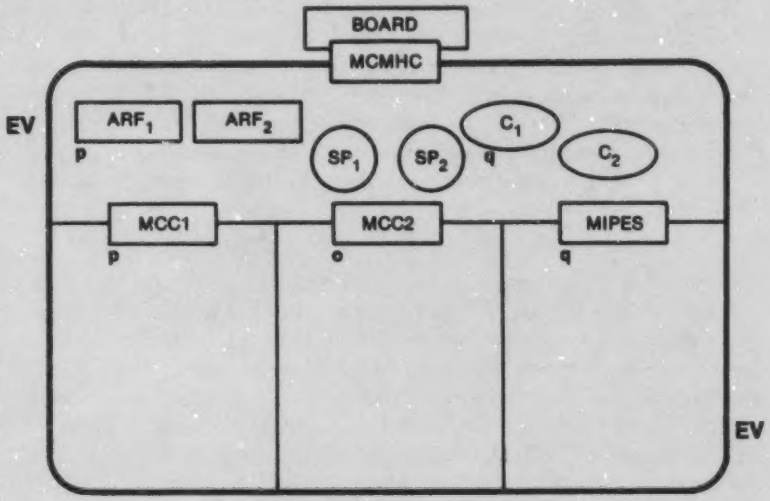
The analytic framework described is useful for obtaining a rough idea of the anatomy of the organization but does not show how well an organization functions or how imaginatively and creatively its people perform. However, when the structure is examined, it is possible to identify implicit organizational priorities and spot potential problems. In the following examples* the analytic framework is applied to several actual organizations.

EXAMPLE 1: The first organization considered (see figure 35) is a mental health center with three major semiautonomous components: two community clinics (providing intake, outpatient care, day treatment, and active consultation and education programs) and a hospital-based inpatient and emergency service. Discussions with center personnel uncovered a major problem area: the director of Community Clinic 2 felt that her unit was not receiving a fair share of center resources. Other staff and executives disagreed about

*In these examples, certain organizational aspects have been altered to preserve institutional anonymity.

FIGURE 35

A CMHC with Confounded Organizational Leadership



MCMHC—Center Management
ARF_1 —Budgetary Control Function; managed by individual p
C_1 —Committee Structure, Medical and Professional Staff Organization; managed by individual q
MCC1 —Management of Community Clinic 1; managed by individual p
MCC2 —Management of Community Clinic 2; managed by individual o
MIPES —Management of Inpatient and Emergency Services; managed by individual q

whether or not the clinic was being shortchanged, but they all acknowledged major interpersonal difficulties among the three divisional heads.

Examining the structure revealed the true nature of the problem and suggested its solution. The physician head of the inpatient and emergency services (IPES) also chaired the medical and professional staff group. Consequently he could speak for quality-of-care issues in the organization. The director of Community Clinic 1 also managed the fiscal office of the center. Thus, whenever disputes over resources arose, discussion was short-circuited because the managers of Clinic 1 and the IPES could act from regulatory control and committee bases, as well as from line managerial roles, thus bypassing the head of Community Clinic 2. Decisions were made

without involving the center director or the board. Rather than being recognized as an organizational issue, the problems were routinely ascribed to personality differences among the three key managers.

Not surprisingly, managers often act to increase their influence on decisionmaking in the organization. A manager who occupies both a line managerial position and a major committee or regulatory group chairmanship is in a position to short-circuit normal institutional processes in the allocation of resources and the definition of priorities. Under such circumstances, problems among managers competing for resources may easily be misascribed to interpersonal difficulties.

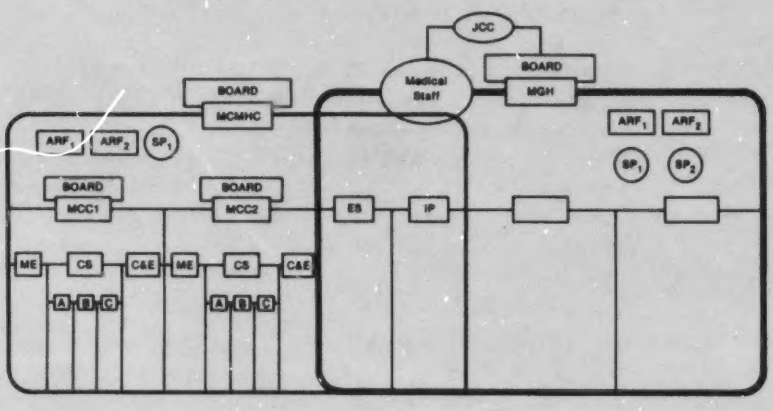
EXAMPLE 2: In community mental health centers, accessibility and availability are usually incorporated into the design of services. Multi-disciplinary teams are involved in assessment and treatment. Nevertheless, services continue to be discontinuous, and patients get lost in the interstices between treatment programs. Significantly, the definition of treatment elements does not necessarily lead to clarity and effectiveness of organizational structure.

Figure 36 depicts a common structure for a community mental health center. The center has two community clinics, each with a local board. Tasks within each clinic are organized into entry, clinical, and consultation and education services. The clinical services offer three locally delivered types of treatment (for example, outpatient, aftercare, and day hospital treatment). This particular center contracts with a general hospital for emergency services and inpatient treatment.

Even a cursory examination of this diagram reveals serious organizational issues. The Emergency and Inpatient Services report to two institutions with different administrative structures and different views about professional functions and interrelationships. Center management must, therefore, carefully define center-hospital interactions in order to maintain some control over both the utilization of center resources and the availability of services to center patients. To ensure that patients are not lost between services and that the psychotic patient population does not become a focus for interunit conflict, inpatient service leadership must participate on center committees. Clinic entry services must work out clear relationships to Hospital (Center) Emergency Services so that patient flow serves individual treatment needs. There are no structures to manage patient flow (export), and these probably should be developed center-wide (e.g., a center placement committee to manage interunit transfers).

FIGURE 36

Organizational Structure: A Decentralized CMHC



MCMHC—Management CMHC
MCC1,2 —Management of Community Clinics
ME —Management of Entry
CS —Management of Clinical Services
A,B,C —Management of Clinical Units
C&E —Management Consultation and Education
MGH —Management General Hospital
ES —Management Emergency Services
IP —Management—Inpatient Services
JCC —Joint Conference Committee

The questions of authority and its exercise are highlighted by the diagram. Responsibility of boards for programs must be made quite explicit lest boards begin to feel impotent or subject to unwarranted interference. The model of a medical staff in one institution will raise questions about appropriate staff structure within the center, questions that cannot easily be resolved. The authority issue is further confounded by clinicians assuming managerial roles. For example, when physicians write orders, are they acting as professionals (M.D.'s), who are using the authority that comes from their specialized knowledge, to instruct others (e.g., nurses) while maintaining a colleague relationship? Are they functioning as senior members of a hierarchical organization using bureaucratic authority? Or, does the act of writing an order invoke different forms of authority at different times?

In the general hospital, the physician is still most often an independent practitioner. From this perspective the physician rarely considers management issues except as impediments to practice. Physician-employees who act as clinician-managers are often confused about the nature and legitimacy of authority. They rarely think about, and even more rarely are taught about, changing role requirements as they move from independent practitioner to clinician-manager. Thus, bureaucratic requirements to function within constraints identified by union-management negotiations may be viewed as inappropriate to good patient care. Requirements to document behaviors and to monitor performance may be eschewed, leading to inconsistent management and the arbitrary delegation and withdrawal of authority. Line managers must always have the capacity, the authority, and the *inclination* to manage.

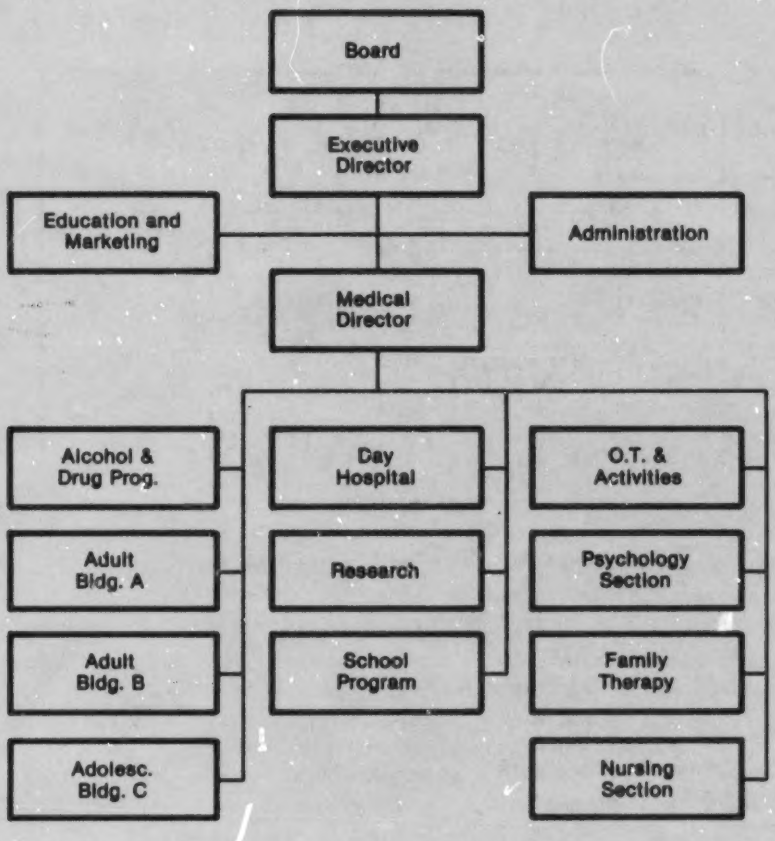
EXAMPLE 3: Several years ago, a private psychiatric hospital experienced some management difficulties. The hospital's organizational charts, shown in figure 37, clearly reflected the source of part of the problem. For example, roles of executive director and medical director were not differentiated, no clear entry structure existed, and line functions were confused with discipline structures. In an attempt to recast the organization into our diagrammatic format, the clinical programs were examined first (see figure 38). Five major units were identified: an alcohol and drug program; two adult buildings and one adolescent building; and a day hospital program. The family therapy program comprised a loose configuration of therapists who worked on different units but who were assigned to patients and their families centrally. This component was primarily a skill pool serving the clinical units by monitoring practice, setting standards, and assisting in education. The occupational therapy and activities program functioned the same way.

The senior executive constellation was indefinite about the relationships among executive director, medical director, and administrator. It was not clear whether they formed a directorate, or whether the medical director had sole responsibility for clinical programs while the administrator was responsible for regulatory functions. The school and research facilities seemed to be relatively separate from clinical operations and were depicted as separate line funtions.

The location of nursing and psychology was initially vague. If they served as major skill pools for clinical, school, and research areas, they should have been located in the sector indicated, but if their function was primarily in the clinical area, perhaps they should have belonged with the family therapy and occupational/activity

FIGURE 37

Organization Chart 1: Hospital X

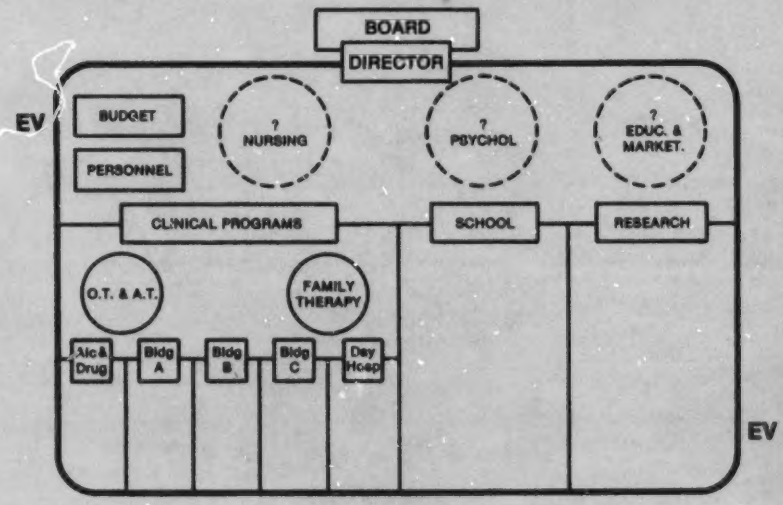


therapy skill pools. The marketing and educational function was a small office involved in establishing continuing education programs and in maintaining relationships with referring professionals. Because it was run by an elderly, respected psychiatrist, it was not considered a component of administration.

The task at hand was to rationalize the organization. Because issues of resource allocation were of major importance in the definition and refinement of organizational structural proposals, a com-

FIGURE 38

Organizational Chart 2: Hospital X



O.T & A.T.—Occupational Therapy and Activities Therapy

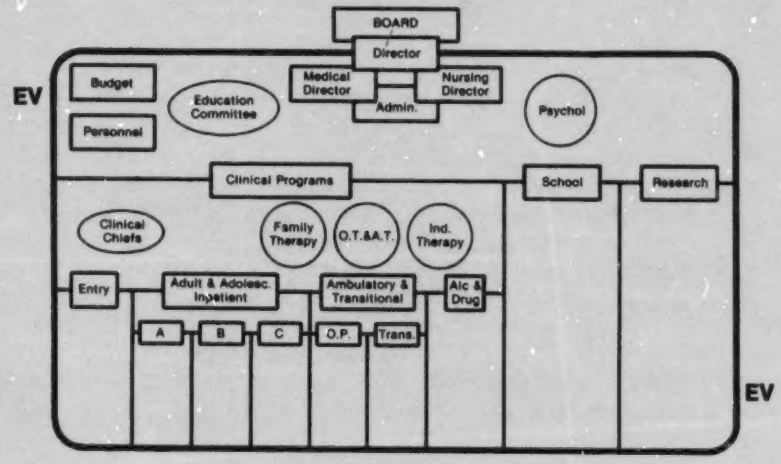
prehensive budget review was undertaken. After much consultation, the organizational structure shown in figure 39 was developed.

The establishment of a neuropsychiatric evaluation unit to serve as an entry system for the entire clinical operation was recommended. That system would deal with referral sources, conduct initial comprehensive evaluations, and develop initial treatment plans. Following evaluation, patients would be referred to a full range of in- and outpatient services within the hospital complex or returned to referring sources. (In the past, the exit processes from the hospital were unstructured and arranged on a case-by-case basis.) Resources for a new entry unit were not immediately available, so it was suggested that 12 beds in one of the adult units be converted to this purpose.

Establishing new beds would, of course, require Health Services Administration (HSA) approval. No regulatory approval would be necessary, however, to start up small ambulatory programs and professional support to transitional living arrangements. The day program was advised to develop transitional settings (halfway houses,

FIGURE 39

Organizational Chart 3: Hospital X



supervised apartments) and serve as a base for a comprehensive institutional ambulatory program.

An individual therapy skill pool whose members might serve patients in a wide range of settings was identified and located under the direct control of the manager of the clinical program. Group and milieu programs were not handled the same way because they seemed to belong to specific units. For example, the group program on the alcohol and drug program was quite different from group programs on inpatient units. These, in turn, were different from programs that might evolve in ambulatory settings. At least initially, these functions should be controlled at the unit level.

The establishment of a clinical chiefs group was recommended to monitor quality of care, develop clinical policies, and facilitate patient transfer (through subcommittees) among units. The directorate of the hospital was changed to include the executive director, the medical director, the administrator, and the director of nursing. This seemed to make sense since the clinical operation accounted for over 85 percent of institutional resources. The medical director was also identified as chief of clinical programs. The psychology skill pool was moved to the institution level because psychologists were actively involved in school and research programs as well as the clinical operations. An educational committee was established,

chaired by the head of the original educational function. However, marketing was really a responsibility of administration. Thus administration became responsible for providing the logistical support for educational activities and exploring marketing strategies as indicated.

This strategy helped the organization clarify its task systems and its structure while pursuing its goals of providing high-quality services, maintaining adequate patient flow, and ensuring fiscal integrity. The process clarified work relationships among managers, identified structures mislocated in relation to task requirements, and distinguished between structures used to deal with the needs of persons or groups and those primarily addressing task needs.

ORGANIZATIONAL IMPLICATIONS FOR REVIEW OF CARE

Quality assurance activities are located in organizational structures in ways which are designed to facilitate work. The relative autonomy of professional groups also has impact upon where these activities will be located. In this section we will look at three different institutions—the hospital, a centralized CMHC, and a decentralized CMHC—in order to examine the impact of differing organizational contexts, interprofessional role hierarchies, and intergroup conflicts upon the location of quality assurance activities.

The Hospital

The modern hospital is a good example of an organizational structure similar in important ways to other health care and human service organizations but with important differences also. Hospitals are usually multimillion-dollar operations that, to a very large extent, depend upon the referral practices of physicians in the community, not on the activities of their employees. A hospital's vitality depends upon its bed occupancy. *Physicians control entry into hospital beds.* Thus hospitals compete for physicians and only indirectly for patients. The extraordinary development of medical technology attests to the conviction of hospitals that if they cannot offer the most extensive services they will lose out in the competition for doctors, and patients will be admitted elsewhere.

Problems of Entry

In a peculiar way the hospital provides a model for entry for health and human service institutions. The applicant for service usually is related to a specific professional who, in turn, is often

responsible for initial workup and services within the system. The hospital's role in the entry process generally is administrative (e.g., determining whether the patient has funds to pay for care, processing forms so that the individual is identified as being within the system, providing the individual with laboratory, clinical, and housekeeping services, etc.). The system works reasonably well for those individuals who have physicians; it works poorly for those who don't. These individuals can enter a hospital only through emergency services or specialty clinics. Usually, no well-designed structure enables them to move from the hospital into outpatient care. In a prior generation, they became charity cases. Today, they may be assigned to junior staff members or advanced trainees. Their entry into the system is precarious. Even when entry is effected, they often have no ongoing relationship to a physican in a setting where a close physician-patient relationship is critically important for ensuring adequate care.

The Export Function

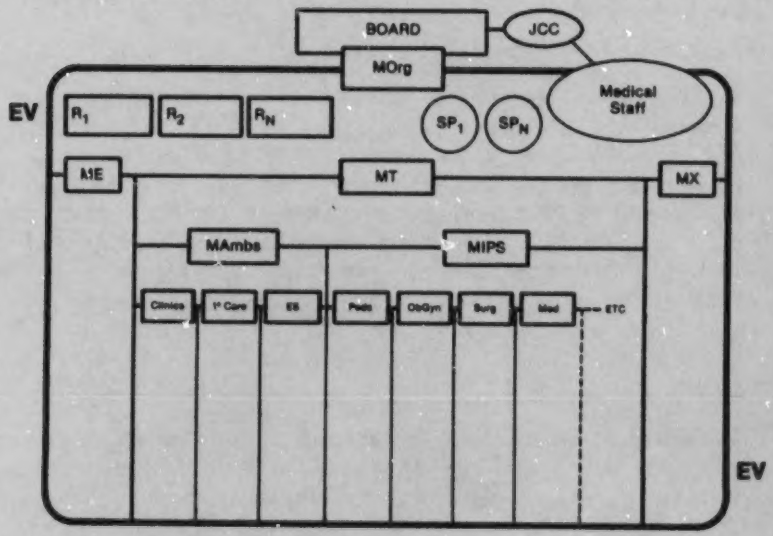
In health and human service organizations, export structures are even generally less developed than entry systems. Administrative systems may follow the patient to the community via billing and insurance procedures, but clinical-care connections usually are limited. The hospital may send some individuals out into its ambulatory services, and the needs of some few patients for community-based social and rehabilitative services may be managed through a small social-work department. However, the hospital generally pays little attention to planning for the complexities of post-hospital care. To an extent some of these "lacks" are made up for by ex-patient groups (laryngectomy groups, colostomy groups, etc.). However, most hospitals view almost all their efforts as properly located in the transformation area.

The Medical Staff in the Organizational Structure

The medical skill pool is in and out of the hospital and, generally, has a uniquely defined relationship to the hospital's board through its joint conference committee (see figure 40). This committee is required by the Joint Commission on Accreditation of Hospitals. It brings together members of the hospital board, the hospital administrator, and members of the medical staff to ensure that patient-care needs will be routinely addressed by the board as it considers policies and priorities. Thus the medical staff is and is not part of the hospital's table of organization. This leads to two lines of accountability within most hospitals: physicians are responsible for

FIGURE 40

The Hospital (Organizational Structure)



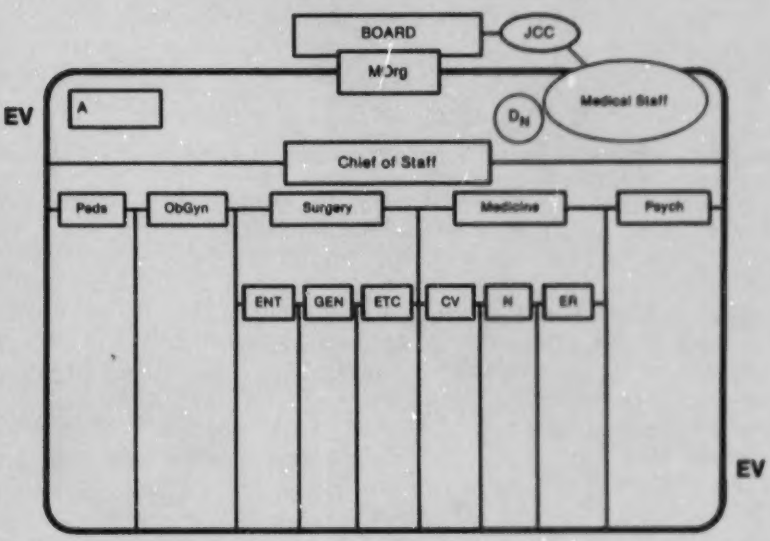
MAmbs—Management Ambulatory Services
MIPS —Management Inpatient Services
1° Care—Management Primary Care Unit
ES —Management Emergency Services

patient care, and staff are separately accountable to them and to hospital administration. Clearly this is an issue which has only recently been recognized by hospital administrators and boards (Neuhauser 1978; Smith 1955).

The physician tends to view the hospital as an extension of his office (see figure 41). Even the limited entry and export functions tend to be dismissed as unnecessary or as administrative trivia. As the "doctor's workplace," the hospital serves his needs, his view of what is necessary for the best patient care. However, the physician expects this complex system to function well without activities being organized (or at least not his activities). Thus, medical, nursing, and dietary services are often at odds with one another, with doctors expecting their orders to be routinely and expeditiously executed even in areas other than direct patient care.

FIGURE 41

The Hospital (Medical Perspective)



A —Administration (undefined)
DN —Other Disciplines
JCC—Joint Conference Committee

Organizational Implications for Review of Care

In the hospital, review of care is almost entirely identified with review of medical activity. Care delivered by other professionals or nonprofessionals is regarded as under the direct supervision of hospital administrators who monitor it through individual performance evaluation. Thus, the logical place for admission certification and length-of-stay certification activities is with the utilization review committee and its physician members so that issues can be resolved peer to peer.

Quality assurance activities are organizationally problematic. They relate directly to the medical staff, but as part of hospital management they must relate to administration.

Medical care evaluation studies and profile analysis are important administrative tools. Responsibility for effectively undertaking those activities might reside either within the hospital's ad-

ministrative structure or with the medical staff. It is clearly in a hospital's interest to exert some control over these activities and in this process to begin exerting some significant influence over the activities of the medical staff. We can anticipate that one effect of the development of more formal quality assurance programs may be some redefinition of and attempts to constrain the role of physician within the hospital.

The Community Mental Health Center

In the consideration of where to locate a quality assurance structure within a CMHC, several organizational issues need to be taken into account. First, within most centers, the professional staff, including physicians, are employees and are bound by institutional regulations and practice. Although the professional staff must have responsibility for the quality of care within the institution, the location of discipline groups and a professional and/or medical staff organization is *internal* to the center. The professional and/or medical staff is *not* a boundary group.

Assigning quality assurance activities to a medical and/or professional staff body gives that staff both regulatory and skill-pool functions. This confounding of tasks can lead to the development of a strong professional group which might conceivably lead to clinical staff/managerial difficulties. Nonetheless, such combining of tasks is important because a strong, committed medical and/or professional staff can have dramatic impact upon its members, monitoring individual compliance with generally accepted criteria and stimulating and supporting staff educational activities.

The utilization review committee (URC) should also report directly to center management profile data and results of clinical care evaluation studies. Information about individual practitioners should be referred to center management only via the professional staff, but other data can be forwarded directly by the URC.

Such organization builds into the utilization review committee the potential for reflecting conflicts between medical and/or professional staff and center administration. Unlike the hospital, the professional and/or medical staff have no way of circumventing administration in negotiating resource demands for clinical needs with center management who are responsible for accomplishing the multiple tasks of an organization (e.g., outreach programs, consultation and education programs, in-staff training, affirmative action programs for employment upgrading) within defined fiscal limits. The organization also benefits by having structures in which these issues can be debated.

Figure 42 diagrams a somewhat idealized quality assurance structure in which the URC is accountable to an organized professional staff that has explicitly defined institutional responsibility for the quality of care. One of the most useful aspects of designing a URC is clarifying who is responsible for the quality of care, an issue poorly defined in most mental health facilities (even those with medical and/or professional staff by-laws). If the medical and/or professional staff has not been delegated responsibility for clinical care, the URC should be located as a committee of that group which does have such responsibility.

A Centralized CMHC

Figure 43 represents a relatively centralized community mental health center with two decentralized services providing local intake, clinical, and consultation and evaluation services. Emergency and inpatient services are centrally located with core administrative activities and special programs (a substance-abuse unit). In this setting a utilization review committee can report directly to the professional and/or medical staff and tie into organizational management. The utilization review committee serves as an important regulatory body for the entire institution, as well as overseeing clinical care activities within the institution.

FIGURE 42

Utilization Review Committee: Organizational Issues

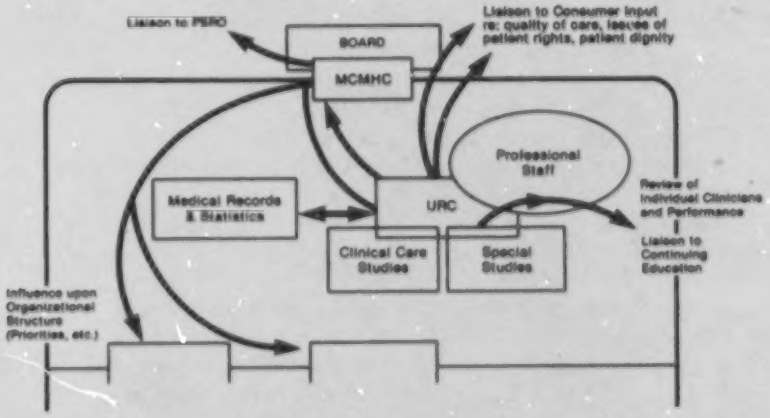
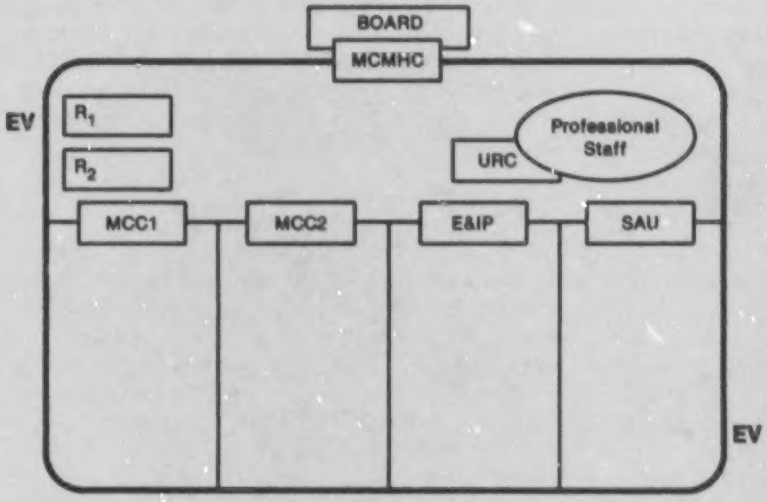


FIGURE 43

Organizational Structure: Centralized CMH



SAU—Management of Substance Abuse Unit
URC—Utilization Review Committee

A Decentralized CMHC

The CMHC shown in Figure 36 (page 129) and described in Example 2 represents a rather typical decentralized center. It contracts for its emergency services and inpatient treatment with a general hospital that has its own utilization review committee and medical staff organization reporting into its own board.

Some decentralized centers may have professional staff organizations, but this model center has no specific utilization review committee. A variety of options are open in regard to utilization review and peer review:

1. The general hospital's utilization review committee, as part of its routine functions, will have responsibility for reviewing admissions, extended stay, and so on, on the psychiatric ward. The CMHC might contract with the hospital for the total spec-

trum of activities required, including medical care evaluation and profile analysis;

2. The center might establish it own utilization review committee responsible to a professional and/or medical staff organization. The committee might insist upon its legitimate review functions in regard to concurrent review (admission certification and extended stay) and retrospective as well as medical or clinical care evaluation studies and profile analysis. That is, the CMHC could compete with the hospital for the right to review activities. However, this strategy is almost always feckless. Hospital review practices will be in place well before most CMHCs have even begun to consider how to establish review structures;

3. A third option might be to have each community clinic separately evaluate its own clinical care and to delegate the responsibility for evaluation of hospital care episodes to the general hospital's utilization review committee. The hospital, in other words, would conduct concurrent review activities, profile analyses, and clinical care evaluation studies. In this decentralized review model the center would conduct all those studies which cross clinical unit boundaries. Since an institution learns a good deal about itself by developing clinical or medical care evaluation studies and profile analysis, it is in the institution's interest to exert some direct control over these activity areas in order to anticipate the need for change and then to plan for redefinition of program or reallocation of resources;

4. The center might join with other centers to develop mechanisms to share resources to collaboratively develop profiles and conduct clinical care evaluation studies. Staff sharing might also enable centers with few professionals to conduct concurrent review activities by clinicians who are not directly providing the bulk of the center's services.

Resource Allocation

The work of a utilization review committee demands adequate staff. At the very least, staff must be available to do admission cer-

tification of high-cost clinical activities. Resources are also required to undertake clinical care evaluation studies and profile analyses.

Although it is important that the utilization review committee be independent of the medical records section, it must be able to command resources and collaboration from medical records. As part of the overall administrative structure of the facility, the major task of the medical records section is to ensure that adequate records are available to assist clinicians in the provision of care. Its secondary task is transmitting and retrieving records from other care givers, again to enhance care. If the records section is also asked to assist in peer review, it must have sufficient staff to accomplish this work in addition to its primary tasks. When there is conflict about allocation of resources or when resources are scarce, the medical records section will naturally focus on the tasks of highest priority.

Utilization review can ensure access to medical records by supporting a records clerk assigned from utilization review staffing, or by having a URC staff member assigned to records and accountable to both sections. To some extent, staffing decisions will be related to volume of work. If the facility has computerized statistics and data-gathering capacity, such services must also be available to utilization review.

REFERENCES

Edelson, M. *Sociotherapy and Psychotherapy.* Chicago: University of Chicago Press, 1970.

Henry, J. The formal structure of a psychiatric hospital. *Psychiatry,* 2:139-151, 1954.

Hodgson, E. C.; Levinson, D. J.; and Zaleznik, A. *The Executive Role in Constellation: An Analysis of Personality and Role Relationships in Management.* Cambridge, Mass. Harvard Business School, 1965.

Miller, E. J., and Rice, A. K. *Systems of Organization.* London: Tavistock Publications, 1967.

Neuhauser, D. The hospital as a matrix organization. In: Kovner, A. R., and Neuhauser, D., eds. *Health Services Management.* Ann Arbor, Mich.: Health Administration Press, 1978.

Rice, A. K. *The Enterprise and Its Environment.* London: Tavistock Publications, 1963.

Smith, H. L. Two lines of authority are one too many. *Modern Hospital,* 84:59-64, 1955.

CHAPTER EIGHT

ESTABLISHING A UTILIZATION REVIEW COMMITTEE

This chapter provides specific guidelines for the establishment of a URC, e.g., selection of members, task assignment, task definition, methods of conducting concurrent and retrospective reviews, and disciplinary or other actions as a result of reviews. It notes the need for explicit written plans and by-laws and clear authority, in order to comply with Federal regulations. A case example of the UR process is presented.

KEY TOPICS

- Establishing a utilization review committee
- Requirements under Federal regulations
- Participation on the URC
- Functions of the URC
- Methods of case selection
- Maintenance of adequate records

CHAPTER EIGHT

ESTABLISHING A UTILIZATION REVIEW COMMITTEE

The objectives of quality assurance programs are broadly conceived of as two-fold: (1) to assure effective and efficient facility use and (2) to continually monitor the appropriateness and adequacy of services provided. In other words, quality assurance represents that element of program evaluation aimed at monitoring the quality of service and ensuring, simultaneously, that it is provided in a timely and economic fashion. The organizational structure most appropriate for carrying out this work is usually the utilization review committee.

Currently, Federal regulations have been promulgated for quality assurance tasks under PSRO, Medicare, Medicaid legislation, etc. CMHC draft regulations called for:

- a written plan describing the structural and functional aspects of the quality assurance program;
- the delegation of responsibility for quality assurance activity to a committee established either for that unique function (a utilization review committee) or for some other function and able to oversee the review systems;

- a review of admissions, duration of stay, and professional services furnished to assess the need for the services and to promote the most efficient use of available services and facilities;
- the conduct of clinical care evaluation studies which focus on selected problem areas and review any aspect of care furnished that can result in recommendations beneficial to the patient, the institution, or the community.

The ideal utilization review committee, with at least a full-time head and some administrative assistance, would have direct access to a medical records and statistics section and liaison either formally to a patient ombudsman or informally to consumers in order to monitor the quality of care and issues of patient rights and dignity. The utilization review committee would be multidisciplinary with participants from the various subunits of the organization.

Figure 44 outlines the development of a quality assessment plan. It emphasizes the tasks which the utilization review committee must accomplish. When other standing committees concerned with evaluating aspects of patient care, such as admissions, medical records, and medical audit committees already exist, the utilization review function may be assigned to one or more of them. However, if possible, a specific organizational entity should have responsibility for institutional utilization review activities. If a particular center is too small to properly conduct utilization review, assistance can be requested from an outside source. CMHCs serving the same general region may benefit from combining utilization review activities for several agencies. A community-based utilization review plan offers special advantages by promoting uniformly high standards of care for institutions within a particular area, identifying needed community health services, and assuring that the health resources of the community are maximally useful to the population. Community-based utilization review plans also stimulate "interinstitutional relationships" and exchange of information, benefitting the individual patient and the community.

MEMBERSHIP

Committee memberships should reflect the entire scope of those engaged in practice within an institution. As a general rule, all disciplines primarily involved in patient care merit consideration for membership. In a smaller center, representation might be structured by discipline. In committees serving centers organized along

the unit system, or serving several centers, all major facilities, services, and affiliates should certainly be represented. In large centers, it might be advisable to establish separate subcommittees for each major program area.

Since many issues raised during the review will be related to administrative policy, the facility administrator or designated sur-

FIGURE 44

An Outline for Developing a Quality Assessment Plan

I. Indicate the tasks and functions that will be included as part of the quality assessment effort, e.g., concurrent review, profile analysis, clinical care evaluation studies, the preparation and dissemination of reports, etc.

II. Describe the organization of the quality assessment effort including:

- A. committee and subcommittee structure and composition (almost always a utilization review committee)
- B. the relationship of committee structure to the tasks and functions outlined in I.
- C. the method of selecting committee members
- D. the term of a member's appointment
- E. the method of selecting a committee chairman, the term of the chairman's appointment, and the responsibilities inherent in the role
- F. the relationship of the committee(s) to other organizational elements within the center, e.g., administration, medical records, program evaluation, etc.
- G. the frequency of meetings
- H. the type of records that will be kept.

III. Describe the quality assessment process including:

- A. the authority of the committee(s)
- B. procedures for admission certification and continued stay review
- C. methods for case selection related to both concurrent and retrospective quality assurance review on a case-by-case basis
- D. methods for topic selection in relation to CCE studies
- E. methods for the generation of profiles
- F. the approach to developing and/or revising norms, criteria, and standards.

IV. Indicate the relationship of the quality assessment effort to claims review.

V. Specify the method for transmitting review findings to administrative and clinical staff, the governing body, and continuing education programs.

VI. Describe followup procedures for monitoring the status of committee recommendations.

rogate should serve as a member or member ex-officio. Staff responsible for recordkeeping and data processing should also sit with the committee on a regular or ex-officio status. When specific studies are commissioned by the committee, by-laws should allow for the temporary appointment of staff who have special competence in the areas being studied. In order to provide continuity, a member's term of appointment should probably be for more than one year, with only a portion of membership changing each year. Membership should not be determined solely on the basis of authority or experience, and representation should be open to staff at all levels (i.e., director of outpatient service, staff nurse, community health worker, chief of social work, etc.).

The selection of a chairperson should reflect the importance ascribed the task, resolving the question of clinician or nonclinician on the basis of the center's by-laws, the task of the chairperson, and the institution's history of interdisciplinary working relationships.

Meetings of the committee as a whole should occur at least once a month and more frequently when deemed necessary. While assignments may be given to subcommittees or individual committee members, final responsibility for overseeing the review function must rest with the committee as a whole.

FUNCTIONS OF THE COMMITTEE

The specific functions of the committee are identified in figure 45. The committee has weighty responsibilities for developing policy and procedures in relation to the quality assurance process and for explicating its relationship to third-party claims administration. It must, therefore, arrange for admission certification, monitor each case of extended duration, and oversee the retrospective and concurrent review activities of the organization.

CRITERIA AND CRITERIA DEVELOPMENT

To expedite the review process, the formulation and use of preestablished criteria are strongly advised. Such criteria are not intended to provide rigid and inflexible codes of conduct. They do not represent a "cook book" of infallible, inedible recipes. Rather, they function primarily as screening devices. Screening is defined as the process by which criteria, norms, or standards are used to examine large numbers of cases in order to select a limited number for more substantive review. Criteria have already been established for screening on issues such as the need for treatment, the need for services received, the need for continued treatment, and the adequacy of care.

FIGURE 45

An Outline for an Annual Report Describing the Activities of a Utilization Review Committee

I. Concurrent Review:
   A. Admission Certification
      1. number of cases reviewed
      2. number of approvals/disapprovals
         a. of the disapprovals, number of cases approved/disapproved by clinician reviewer.
      3. narrative as required for explication
   B. Continued Stay Review (CSR)
      1. number of cases reviewed
      2. number of approvals/disapprovals
         a. of the disapprovals, number approved/disapproved by clinician review
      3. narrative description as required for explication

II. Profile Analysis:
   A. Summary of activity including routine and special profiles developed
   B. Identification of follow-up activities stemming from profile analyses

III. Clinical Care Evaluation Studies (CCE):
   A. Summary of all CCE studies undertaken including results

IV. Action taken based upon the activities outlined in I, II, and III as related to:
   A. Individual clinicians
   B. Service units
   C. Service programs
   D. Institutional policy and procedure
   E. Continuing education

INDIVIDUAL CASE REVIEW

While screening can be accomplished by nonclinicians, sufficient latitude should be provided to the review coordinator to interact with clinical personnel and clinician reviewers prior to final decisions. Final decisions related to the care of an individual patient, however, must be made by a clinician reviewer or peer. Such peer review is mandatory in *any* instance where variance from preestablished criteria could (1) preclude the continued receipt of services or (2) be associated with recommendations to change the level of care provided.

In addition, all persons conducting individual case review should be encouraged to seek additional information from sources other than the record or the abstract or the administrative summary forms that exist. The committee, therefore, should develop a general policy as to those conditions under which additional information should be solicited and the manner in which it should be obtained. These policies must rigorously protect the confidentiality of both patient and clinician.

THE CASE REVIEW PROCESS

To expedite review of individual cases, a three-level process is suggested. The first level involves examining charts of all patients admitted to treatment to establish the completeness of the information contained in the chart. This can be accomplished by personnel in the record room and is a legitimate medical records department function. Charts which do not meet minimal standards of completeness should be returned to the attending clinician. Second-level review considers whether or not the treatment is appropriate according to screening criteria established by the institution. These criteria can address such questions as: What circumstances justify hospitalization? Within what time frame should psychotropic medication regimens be reviewed? What symptom constellations merit a neurological examination?

Judgments of this nature can be fully operationalized and embodied in a standard case abstract. In this manner, simple yes/no discriminations can be made. If the second-level reviewer finds any deviations, then those charts are given a third-level or clinical review under the supervision of the committee. In this review, a clinician examines the chart, and may, using established guidelines, seek other information in order to determine whether the specific treatment being questioned is inappropriate or appropriate but unusual, or whether the criteria themselves require further refining. Such peer review is mandatory whenever a variance from criteria would preclude continued treatment.

CASE SELECTION METHODS

A criteria-oriented approach is useful in organizing information for clinical care evaluation studies. In performing such studies, major issues are related to selection of study topics. Four basic mechanisms have been suggested, and it may be useful for an institution to develop evaluation studies utilizing all four methods in order to maximize the probability of identifying instances of inappropriate care. These methods include:

1. **Random Selection.** Cases are chosen in a random method which will, over time, guarantee that some cases from each unit and each clinician are reviewed.

2. **Selection on the Basis of Problem Type or Service Unit.** At times, a need may arise to review care in a relationship to a problem of identified institutional concern, or to monitor care in a unit in which organizational problems may be predicted to interfere with patient care. A URC may elect to focus on patients on long-term phenothiazine use to explore issues in regard to prescription and side effects. It may emphasize a current problem area, such as increase in adolescents signing out against medical advice. The cases selected for review would all reflect the problem or the unit to be studied.

3. **Selection on the Basis of an Exception to Established Practice.** Here all cases which explicitly *deviate from established clinical criteria* would be reviewed. For instance, a particular facility may have established a criterion that all patients with a diagnosis of schizophrenia should receive phenothiazines. The Utilization Review Committee could then request from treatment units or clinicians a list of schizophrenic patients not receiving the phenothiazines. These cases could then be subject to more detailed review. Drug dosage ranges might be established, and prescriptions exceeding or less than recommended dosage might be routinely subject to review.

4. **Selection on the Basis of Pattern Analysis.** In this instance charts are selected which deviate from statistical norms established through pattern analysis. Such selection is facilitated by computerized records systems. For instance, cases could be selected in which the pattern of care such as duration of stay, or type of treatment, deviates in either direction from the norm, for a specific patient in a given diagnostic category receiving treatment upon a given service. The computer program which automatically selects cases can report a series of such cases on a regular basis to the Utilization Review Committee.

RECORDS AND REPORTS

The committee must maintain adequate records of its activities. Summaries can be developed from data reported by members, from the comments and critiques of case reviewers, and from results of clinical care evaluation studies. The summaries of each discrete activity may be incorporated in the committee's minutes. All records of the committee, including the review forms/abstract/reviewer's comments, however, must be regarded as confidential and not filed with the patient's record of note.

Questions of confidentiality demand special attention. The quality assurance process is oriented toward improving care, and all interventions based upon the work and findings of quality assurance programs must rigorously adhere to established procedures with great concern for the rights of patients and clinicians lest the entire program be seen as repressive, destructive of good care and interpersonal relationships, and an impediment to clinical work. To the extent that URC actitivies are viewed as elements of an institution's management structure, and divorced from medical and/or professional staff self-regulation, the protection of these records may be in jeopardy.

The utilization review committee is responsible not only for reviewing the status of care but also for commenting upon it and recommending possible avenues of correction. To be effective, staff members and administrative personnel must thoroughly understand the scope and function of the review process. Reports should be made regularly to the center's executive committee, and relevant information should be made available to the entire staff, the administrator, and the governing body. Results of special studies, as well as recommendations, should be thoroughly discussed and used as the basis for a continuing education program for the entire staff. When care provided by an individual is seen as inadequate, the clinician should be approached directly by a peer reviewer and a program of corrective action identified. Such activities must be kept highly confidential. If corrective action is not successful, formal channels must be identified for the orderly conduct of requisite disciplinary action. Since many clinicians may view this entire process as a means of coming between the patient and clinician, the work of a utilization review committee must be generally acceptable by clinicians before any disciplinary action is even contemplated. Without extensive involvement of clinicians in the review process, the committee will have little institutional impact. The quality assurance program must demonstrate its ability to enhance patient care.

An annual report should summarize all recommendations made and actions taken, including educational, administrative, and programmatic concerns related to either the efficiency of facility use or the quality of care provided. We include as an appendix to this chapter sample committee reports which may provide a useful model for an annual report format.

The findings generated from utilization and peer review should also be routinely employed to assess the adequacy of the screening mechanisms and criteria in order to identify areas requiring modification. The review process and the activity of the committee should always reflect the most current statement of appropriate patterns of treatment.

A utilization review structure and an effective quality assurance plan provide information about the functioning of the organization to the organization and its members. Such information is inherently valuable to management as it allows for early corrective interventions into problem areas and identifies possible needs to reallocate or generate additional institutional resources. If the review process only limits activities and does not help the institution generate resources in order to address new problem areas, the process will become rapidly bureaucratized and essentially ineffectual.

To illustrate the development of the utilization review process, there is presented here a case example that is a composite of the experience of mental health professionals with responsibility for quality assurance programs in different mental health settings. The description of the Utilization Review Committee in a hypothetical setting provides a perspective into the complexity of the UR process. Through annual reports included in the case study, the reader can follow the evolution of the UR system over a period of three years. Though brief, these reports provide a glimpse into the progression of steps in the development of the system.

EASTERN MENTAL HEALTH CENTER (EMHC)

UTILIZATION REVIEW COMMITTEE:

Summary of Activities 1972-1975*

*This case is excerpted from "Utilization Review in Mental Health: A Case Example" that originally appeared in *Evaluating Community Mental Health Services: Principles and Practice*, edited by I. Davidoff, M. Guttentag, and J. Offutt. DHEW Publication No. (ADM) 77-465, 1977.

EASTERN MENTAL HEALTH CENTER (EMHC)

UTILIZATION REVIEW COMMITTEE: Summary of Activities 1972-1975*

The Process Begins

At the EMHC, development of the utilization review process began with the establishment of the Utilization Review Work Group to advise on and collaborate in the development of the Utilization Review Plan. Though major responsibility for implementing the plan was assigned to the CMHC's Utilization Review Committee, the Work Group continued to play an important role in the UR process. During the first year of the Utilization Review Committee's operation, a proposed UR plan was presented by the committee to the director and Executive Committee of the EMHC. Final approval was, however, delayed until the URC's second year of operation.

As a first step, the Work Group members outlined the following principles which at a minimum they considered essential to a "workable" utilization review model.

1. The UR plan should demonstrate the utility and interrelationships of component parts of the UR system.
2. Explicit standards for adequacy of care should be developed that reflect on assessment of factors such as diagnosis (schizophrenia), symptom (suicide), developmental period (adolescence), and institutional process (intake).
3. Criteria for care should be defined.
4. Mechanisms should be constructed for case selections for utilization review based on norms developed by professional panels and upon detailed analysis of patterns of care.
5. Components of the review mechanism should be implemented as soon as practical.

*The first major research project on developing a methodology for utilization review of mental health services was initiated by an interdisciplinary team at Yale University in 1969. The model system of patient care review is described in Reidel, Donald C.; Tischler, Gary L.; and Myers, Jerome K. eds., *Patient Care Evaluation in Mental Health Programs.* Cambridge, Mass.; Ballinger Publishing Company, 1974.

6. Problems involved in setting up and implementing the UR model should be documented.
7. Feedback mechanisms should be integrated into the system so that findings can influence policy, administration, and services.

UTILIZATION REVIEW COMMITTEE PLAN

Upon the recommendation of the Clinical Chiefs' Committee (CCC), the URC was authorized in June, 1972, by the director and the Executive Committee of EMHC as a subcommittee of the Clinical Chiefs' Committee and accountable to it for the performance of its tasks.

It was specified that the Utilization Review Plan to be developed by the URC required approval by the Clinical Chiefs' Committee of EMHC prior to its adoption.

In accordance with the tasks and procedures outlined in the URC plan, the URC was assigned the authority to review the chart of any patient of EMHC and discuss the management of any case with appropriate staff. Interviews with patients or former patients would normally be preceded by discussions with clinicians or former clinicians, and principles of confidentiality would be respected.

The chairman of URC would be a member of the Clinical Chiefs' Committee, representing the views of URC based on URC experience with reviewed issues. Through regular participation on CCC, he would be informed regarding current patient care issues raised in committee and share information regarding URC activities with CCC.

In its first phase of development, URC would cooperate with the UR Work Group, by providing it with a copy of the minutes of URC monthly meetings and of special reports.

Specific URC procedures and functions were approved as described below.

URC Functions

The Utilization Review Committee of the Eastern Mental Health Center has the task of developing a utilization review plan to monitor the level of care provided to patients. The committee's functions are as follows:

1. Supervising all utilization review activities as related to individual patient care and appropriate use of EMHC resources.
2. Defining extended duration, evaluating over- and under-use of treatment, and routinely reviewing cases of extended duration.
3. Collaborating with the UR Work Group which by an examination of charts provides monthly reports to the URC summarizing the results of individual case review.
4. Reviewing, analyzing and interpreting the weekly, monthly, quarterly, and annual statistics prepared by the Statistical and Record Center, and formulating policy recommendations based on this analysis.

5. Undertaking special studies that relate to the utilization of services, their relevance to community needs and the systems of service delivery.
6. Devising the means by which the quality of care may be appraised from the perspective of the patient-consumer.
7. Establishing other ways to monitor the level of patient care in the EMHC in addition to individual chart review as performed by the UR Work Group.
8. Developing other activities related to studying utilization in the EMHC and possible improvement in patient care.
9. Reporting URC findings to the Clinical Chiefs' Committee, particularly deviations from standards of appropriate care and URC's recommendations for procedural changes that affect patient care.
10. Translating the findings of the URC into recommendations for staff training.
11. Providing feedback to appropriate persons, including the sharing of material, reports and special studies, thereby conforming to URC's purpose of providing an objective and educational peer review mechanism.

The general functions of URC are defined in terms of permanent subcommittees on Patient Care Review and Consumer Opinion, and provide for Program Evaluation Task Forces. While subcommittee structure is subject to change, it is expected that similar methodological approaches will be used in the future, regardless of structure.

Findings and recommendations are presented to the full URC for its approval or disapproval and approved URC recommendations are subsequently presented to the Clinical Chiefs' Committee for its approval and implementation or its disapproval.

URC Procedures

1. Individual patient care review tasks include:
   A. Collaborative work with the Work Group toward improving the current system of review and developing alternative review approaches. Work Group Monthly Reports identify cases that merit further review in accordance with Work Group standards. Such standards are also open to revision as a result of URC review.
   B. Development and testing of mechanisms to report findings to clinicians, supervisors and unit chiefs regarding the quality of patient care and its impact on the ongoing program of the EMHC.
   C. Periodic evaluation of the efforts of URC, with a review of its results, issues and methodologies.
   D. Review of the clinical management of patients:
      (1) Selected from Work Group screening
      (2) From selected clinical services
      (3) Selected by symptom, diagnosis, age, ethnic characteristics, etc.

(4) Who died from any cause
(5) In the defined category of extended duration of treatment
(6) Selected from the defined category of under-use of treatment
(7) Selected on the issue of appropriateness of:
(a) Admission
(b) Treatment plan
(c) Continuity of care
(d) Discharge plan
(e) Supportive services (internal and external)

E. Procedures that enable reviewers to become familiar with the management of the case through review of the chart and Work Group consultant's comments, and discussion as appropriate with the consultant, clinician, supervisor, unit chief and patient.
F. Periodic review of previously studied problems in order to assess what effect, if any, previous recommendations have had on quality of programs.

2. Work Group staff will focus on cases that contain questionable areas primarily related to recording.
3. Patient Care Review Subcommittee(s) meets twice a month and small working groups may meet more frequently. Reviewers, working singly or in pairs, present findings to the full subcommittee and subsequently to the full URC. After approval, they are presented to the Clinical Chiefs' Committee for its approval and implementation or its disapproval.
4. Through Program Evaluation Task Forces, URC will conduct studies of the quality of patient care. These studies will:
A. Analyze and interpret statistical reports regarding patient care (weekly, monthly, quarterly, annually).
B. Request special statistical reports as needed.
C. Study and interpret specific problems in EMHC referred by the Clinical Chiefs' Committee, division heads, et al.
D. Study documents of service units and departments when relevant to committee tasks.
E. Participate in defining extended and under-use of treatment.
F. Refer selected areas of study to Patient Care Review Subcommittee(s) for individual case review.
G. Study patterns of preventative as well as direct services.
H. Periodically review previously studied problems in order to assess what effect, if any, previous recommendations have had on quality of programs.
5. Program Evaluation Task Forces will present their findings to the full URC for its approval and subsequently to the Clinical Chiefs' Committee for its approval and implementation or its disapproval.
6. While Patient Care Review Subcommittee(s) assesses the quality of care given by clinicians, URC also seeks through a Consumer Opinion Subcommittee to learn how patients and former patients regard the care provided from their perception of needs, wants and expectations.

A. Data may be offered by or actively solicited from consumers, through written means or verbal interviews.
B. Consumer feedback may be sought from a random population of applicants for services or a specific population defined by variables such as demography, diagnosis, treatment plan or outcome. Methods would vary according to focus. Studies of known or suspected problems in the delivery system may also be undertaken.
C. Consumer Opinion Subcommittee meets at least monthly and presents findings and recommendations to the full URC for approval and subsequently to Clinical Chiefs' Committee for its approval and implementation or its disapproval.

URC Member Responsibilities

Each URC member has a responsibility to devote the time and effort necessary for URC to fulfill the committee's tasks. Recognition of each member's contribution of time and effort given to URC requires administrative support within the context of the members' primary and total responsibilities as an EMHC staff member. It is expected that each member accepting appointment offers individual expertise as well as representation from his or her primary service unit.

The chairman is the one person who represents URC to the community. He carries administrative responsibilities for the functioning of URC and is the communicative link to URC subcommittees, its task forces, and its members.

Specific functions of the chairman include:

1. Chairing monthly URC meetings, planning agenda.
2. Chairing meeting of subcommittee heads for the purpose of coordinating various URC activities.
3. Participating ex officio in URC subcommittee meetings with particular responsibility of helping avoid duplication of effort among other committees of URC and of the EMHC.
4. Handling all incoming and outgoing URC communications.
5. Presenting special reports, findings, and recommendations to Clinical Chiefs' Committee and to other appropriate persons.
6. Supervising secretarial and other supportive services related to URC.
7. Maintaining liaison with the UR Work Group.
8. Arranging for specialists to assist URC members in their tasks as needed.
9. Submitting an Annual Utilization Review Report which includes the following information:
   A. A summary of the past year's utilization review activities including a discussion of both special studies and cases of extended duration and under-use of treatment.
   B. Plans for conducting special studies during the next year.

Composition of Membership

The composition of the URC should reflect the importance of its work. The chairman of the committee should be a highly experienced clinician of any discipline who understands the service delivery system of EMHC and has an ability to work effectively with a wide range of staff representing various disciplines as well as with consumers and other agency personnel.

Other members of the committee should be chosen to represent every service offered to patients at the EMHC but not necessarily in terms of administrative units. EMHC staff who are not official members of URC may serve as members of subcommittees and task forces, but not as chairpersons.

Appointment of Members

Initial members of the URC will be appointed by the director of EMHC for a term of one year, commencing July 1, 1972, in accordance with program and disciplinary representation described previously. For the purpose of continuity, there is no provision for alternate representation in the event of illness, vacation, etc., of members.

Members are nominated by chiefs of programs and appointed by the director of EMHC in consultation with the chairman of the Clinical Chiefs' Committee and the chairman of URC.

Terms of appointment will normally be for three years with provision for approximately one-third of the members in rotation. In order to achieve this plan, on July 1, 1973, one-third of the members will be appointed to a one-year term, one-third to a two-year and one-third to a three-year term. By July 1, 1974, all new appointees will be appointed to terms of three years.

The chairman will be appointed by the director of EMHC in consultation with the chairman of the Clinical Chiefs' Committee for a term of one year with eligibility for reappointment.

The representative of the Psychiatric Residents' Association will serve a term of six months (modular placement) or one year (track placement).

EASTERN MENTAL HEALTH CENTER

ANNUAL REPORT 1972 – 1973

UTILIZATION REVIEW COMMITTEE

The Utilization Review Committee of (Eastern Mental Health Center [EMHC]) was authorized by the director and Executive Committee of EMHC in April 1972, upon recommendation of the Clinical Chiefs' Committee. We are fortunate that the UR Work Group, with consultative assistance from a range of mental health professionals, e.g., clinicians, social scientists, epidemiologists, and administrators, had already begun a study of the problems of performing patient care evaluation.

As part of its effort, the Work Group developed a set of criteria for a number of aspects of patient care, from evaluation through treatment. These were applied to assessing the quality of care at the EMHC through its utilization review mechanism. During 1971 the UR Work Group and its consultants developed an individual Chart Review Checklist. The interest, experience and work of this group were, without question, helpful in establishing a Utilization Review Committee at EMHC and provided a head start in coming to grips with its basic task. The Utilization Review Committee received its charge from the director and the organization of the URC was underway.

The chairman, appointed for a term of one year, was relieved of other responsibilities so he would concentrate his primary efforts on URC activities. Committee members were appointed with a view toward reflecting the importance with which the EMHC viewed this work. The committee included representatives of every kind of service offered our patients and included senior clinicians with administrative responsibilities as well as first-line service personnel. The composition of the 21-member committee consists, to our knowledge, of a greater variety of disciplines, clinical experience and credentials than exists in most other URCs. It is truly a reflection of peer review. Three subcommittees were formed at the first monthly meeting held in August:

1. Patient Care Review – to review individual patient care
2. Statistical Analysis and Review – to review and interpret statistical data
3. Consumer Opinion – to learn of the nature of treatment experience from the perspective of the patient or former patient.

Subcommittees generally met twice a month and reported to the full URC whose approval was required before presenting findings and recommendations to the Clinical Chiefs' Committee, of which we were a subcommittee. Immediate tasks were to formulate written statements of tasks and procedures that could be sanctioned by CCC.

A major accomplishment during the nine months of its existence has been to establish a sense of working together among members of the committee. An egalitarian quality of decision-making has been achieved, and the members feel a sense of gratification from their efforts.

An educational focus, rather than punitive, has been felt by clinicians who have interacted with members of URC. A low-keyed approach with accompanying limited publicity in keeping with experimental methodologies employed by the committee, has produced an initial receptivity to the work of URC by clinicians, unit chiefs, and administrators.

By pairing reviewers of different disciplines and varying clinical experience, the reviewers felt an enrichment in their work.

Early questions within URC regarding its authority and integrity have been largely allayed through discussions with the chairman of CCC, and through appointment of the URC chairman to the CCC. The latter step has enabled week-to-week sharing of information regarding overall institutional clinical issues and the work of URC.

Structural questions persist in the committees' efforts to devise the best method to accomplish our tasks, and a total Utilization Review Plan is yet to be presented to CCC for its approval. In the meantime, the subcommittees have been testing methods and engaged in activities that we believe have had or will have a beneficial effect on the quality of patient care at EMHC.

The Patient Care Subcommittee has completed a review of 36 cases in which the issue of Suicide Assessment was studied. Included in this review were three cases of completed suicides. The report has been presented to CCC where it is being actively considered. This review has provided the subcommittee with an initial experience of reviewing charts and written comments of Work Group consultants, of beginning interactions with clinicians, supervisors and unit chiefs.

There is a suggestion that an active Utilization Review process is having a stimulating effect on clinicians and supervisors to complete written documentation of their clinical management of patient care.

The Statistical Analysis and Review Subcommittee would more correctly be termed Special Studies since its interest goes beyond statistics. Its major work has been and continues to be the definition of expected norms of duration of treatment for the various treatment modalities employed within EMHC.

The subcommittee review of the "no show" rate of persons scheduled for evaluation interviews and the number of scheduled and nonscheduled appointments, resulted in recommendations for block-scheduling of a larger number of applicants which led to better utilization of clinicians' time.

There continues to be interest in reviewing the status of our Indirect services to help us learn what we are or should be emphasizing in terms of community needs.

The Consumer Opinion Subcommittee defined "consumer" as a patient or ex-patient of EMHC, searched the professional literature to learn of the experience of other psychiatric facilities in learning from patients their perceptions of the treatment, and is now engaged in a limited experiment, interviewing patients who have given consent to such interaction.

ANNUAL REPORT 1973 – 1974

UTILIZATION REVIEW COMMITTEE

In its second year of existence, URC has made considerable progress on several fronts. This is attributable to the growing ecperience of the members working together, the stability and efforts of the committee members, increased understanding of the purposes of URC by the EMHC staff and the members themselves, and the administrative support evidenced by the leadership of the institution. The structure of URC was changed somewhat. The full committee and Consumer Opinion Subcommittee continue to meet monthly. The Patient Care Subcommittee meets every other week, as it did last year. The Statistical Analysis and Review Subcommittee, which had devoted much of its energy to the development of norms was dissolved, and in its place, task forces have been constituted to address specific needs as they arose. Two task forces have functioned during the year: 1) Norms and 2) Procedures to Review Extended Length of Stay Cases.

STATUS OF URC ACTIVITIES

I. Patient Care Review

A. Suicide Assessment (36 cases, including 3 completed suicides)

1. Recommended that incident report and written unit review with possibility of URC Review, be established as institution-wide procedures in all cases of suicides, serious suicidal gestures and deaths, involving EMHC registered inpatients, outpatients and recently discharged patients (two weeks).
   Approved by Clinical Chiefs' Committee and adopted by Executive Committee.
2. Recommended that documentation be provided when potential for suicide is marked as present on Admission or Mental Status Examination forms.
   Approved by Clinical Chiefs' Committee.
3. Recommended that suicide assessment report be utilized by unit chiefs in orientation, preservice and staff development programs as well as be available in library, for reference.
   Approved by Clinical Chiefs' Committee.

4. Recommended that formulation should be undertaken of what constitutes a lethal supply of medication dispensed at any one time.
   Referred by Clinical Chiefs' Committee to Pharmacy Committee.
5. Recommended that periodic assessment of chronic patients' clinical status and supports be strengthened.
   Referred by Clinical Chiefs' Committee to Medical Records and Information Committee.

B. Assessment of Support (17 cases)
1. Recommended that staff orientation emphasize specific topics, e.g., family and collateral involvement in the evaluation process, relation of low income to mental health, special resources within EMHC and in the greater community.
   Approved by Clinical Chiefs' Committee, referred to training component for implementation.
2. Recommended high risk categories in Work Group's Assessment of Support Checklist include people on welfare, low income, minorities.
   Approved by Clinical Chiefs' Committee; Checklist modified.
3. Developed a checklist to assess systematically support structure of patients. Of potential training use for trainees and staff, report and checklist will be available in library for reference. Checklist will be further expanded to include additional high risk groups.
   Approved by Clinical Chiefs' Committee.

C. Charts Adjudged "Adequate" by Work Group review (14 cases).

Purpose was to test the adequacy of the criteria to discriminate adequate and inadequate patient care at the work group level of review.

Results:
1. The Work Group criteria did discriminate adequate and inadequate care as recorded in the chart.
2. Recommended that significant medical problems, e.g., low or high blood pressure, allergies, drug sensitivities, be noted in Transfer/Discharge summaries and noted again (with changes, if any) at time of patient's readmission on Supplemental Admission Form.
   Approved by Clinical Chiefs' Committee, referred to Medical Records and Information Committee for inclusion in its study of reorganizing documents included in the chart. Pharmacy Committee developed and made Side Effects/Allergic Reactions Report available as a teaching aid for clinicians.

D. AMA (20 cases being reviewed)

This review is currently in process, with no report available at this time.

E. Special Case Review

Administration has referred cases for special review. URC is the

institution-wide mechanism for such a service, whether the request comes from within EMHC or from a source located in the wider community.

II. Consumer Opinion

A. Recommended that suggestion boxes be strategically placed in service areas to learn of patient satisfaction or dissatisfaction with service.
Rejected by Clinical Chiefs' Committee as limited in value.

B. Recommended that pilot study of discharged patients be undertaken to learn consumers' perceptions of the quality of service received.
Approved by Clinical Chiefs' Committee, study in progress.

C. Consumer issues handled by Chairman, URC, from 4/1/73 - 4/1/74, most by personal interviews.

Types of Issues

Billing, Fees	7
Dissatisfaction with clinical services	5
Confidentiality	3
Dissatisfaction with reception	2
Family seeking information	2
Interagency referrals	2
Gaining entry to service	1
Refusal of Blue Cross to approve payment	1
	23

III. Task Force

A. Inpatient Referral Patterns

In the process of reviewing data which led to the recommendation of norms for length of stay for the Inpatient Units, it was noted that, of the patients discharged during a recent 6-month period:

81% from Unit I were referred to another resource
41% from Unit II were referred to another resource

Although it was not possible to conclude definitively what the explanation for the large difference is, it was noted that the two ward populations differ significantly in socio-demographic factors. It is speculated that poor patients without established relationships with private practitioners or clinics are more likely to be discharged without referral.

Further, there is no existing or easily obtained verification that the indication of a referral on a discharge form is actually achieved i.e., there is no systematic followup to establish that continuing care is achieved.

B. Norms

Last year, norms for extended length of stay for two inpatient units were recommended and approved by the Executive Committee:

- Short Hospitalization Unit—14 days
- Eastern Mental Health Center Inpatient Unit—30 days

Continuing its efforts, norms for the long term Inpatient Unit were recommended and approved as follows:

- Diagnosis of Schizophrenia–165 days
- Diagnosis of Affective Disorders–120 days

Norms of 45 days length of stay were recommended, approved and are ready for implementation at an appropriate time for the partial hospitalization units.

The following norms have been recommended for consideration by CCC and by staff of the units to be implemented at an appropriate time:

- Assessment–5 or more clinical sessions
- Brief Treatment–13 or more clinical sessions
- Individual Psychotherapy–62 or more clinical sessions
- Group Psychotherapy–73 or more clinical sessions
- Couples/Family Psychotherapy–59 or more clinical sessions
- Community Support–49 or more clinical sessions

C. Criteria for Necessary Hospitalization

The work of this task force is still in progress.

The intent is to have criteria in place ready for implementation at a time deemed appropriate by EMHC.

IV. Other Activities

A. Review of extended length of stay has been performed by six senior physicians, beginning 7/1/74. Thus far, all eleven of the cases subject to review were justified, in the judgment of all reviewers.

B. A total of 31 incidents of suicide attempts and completions have been reported from 6/20/73 to the present.

C. Consumer issues handled by Chairman, URC, from 4/9/74 through 2/26/75, most by personal interviews:

Types of Issues

Fees	9
Dissatisfaction with services	8
Inter-agency activity	2
Confidentiality	1
Discrimination	1
Gaining entry to service	1
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D. Joint followup activity with administration on a Work Group report that noted a lack of discharge summaries in charts of clients in the Spanish Clinic resulted in a request for staff training sessions in charting, which was subsequently provided.

V. Plans For Next Year

Structural changes in the committee will be considered by the Patient Care Subcommittee. It may meet monthly with provision for task forces to meet during other weeks of the month. Depending on the redefinition of its charge, Consumer Opinion Subcommittee may reconstitute itself. There is no

value to reconsidering the merits of URC being accountable directly to the director or his designate, rather than to the Clinical Chiefs' Committee or its successor.

The Utilization Review Plan will need to be updated reflecting changes in light of our experience and examining its appropriateness in relation to rules and regulations provided by governmental bodies, PSROs et al. URC is providing the mechanism for review of extended length of stay and recommendations of criteria for necessary hospitalization and may eventually participate in the review of justification of admissions.

Several patient care studies will be in process during the year. Selection of studies may be made (but will not be restricted to) from the following issues:

A. Patterns of transfers within EMHC, concentrating on:
   1. Reason(s) for transfer
   2. Factors that affect completion or noncompletion of transfer
B. Characteristics of clients whose multiple use of EMHC is confined to triage
   1. Frequency of use over a two-year period
   2. Characteristics of clients including problem appraisal
C. Over-utilization of continuing care services
   1. Justifications
   2. Comparison of patient and clinician characteristics between over-and-typical-utilizers of services
   3. Costing of EMHC resources
D. Patterns of care and utilization within specialized treatment programs:
   1. Drug and Drug Abuse
   2. Alcohol
   3. Depression
   4. Indirect Services
E. Followup of extended inpatient care retrospective review of possible impact of implementing case review of extended length of stay, from 9/1/75 to present (10 cases)
F. Review of reported suicide attempts and completions, from 6/20/73 to present (31 cases)
G. Study of Work Group reviewed cases presenting institution-wide issues or issues supporting URC-clinician interaction
H. Study of crisis services provided in General Hospital Emergency Room (ER) for EMHC patients and how the referral and followup process works between ER and EMHC.
I. Examination of the process of determining diagnosis and how a diagnosis is used at EMHC
J. Review of adequacy of recording and appropriateness of medications in ongoing patient care
K. Study of levels of care provided by different professional groups, i.e., psychiatrists, psychologists, nurses, social workers, psychiatric aids, chaplains, etc.
L. Assessment of patient satisfaction with services at EMHC

M. Study of patients who are out of the center from Triage and/or Evaluation, to see why the particular referrals were made (this is not to indicate that the referrals were not appropriate)

In general, the work of the Work Group has continued to be a great source of help to URC. It is hoped that URC will make greater use of the wealth of clinical information about patient care. Burgeoning record-keeping demands have kept step with logging and monitoring of review of length of stay in addition to the minute-taking of committee and task force meetings. The six senior psychiatrists who have reviewed extended length of care cases have given freely of their time and expertise and performed their work promptly.

ANNUAL REPORT 1974 – 1975

UTILIZATION REVIEW COMMITTEE

During its third year of activity, URC has implemented plans developed during the previous year and initiated and completed studies of patient care issues. The continuity of its interest and work has been maintained due to the dedication of its membership.

Five members resigned during the year and five had joined the committee in July, representing a significant turnover in membership. Changing service assignments that conflict with URC meetings had its impact on reduced attendance at the monthly meetings.

The Consumer Opinion Subcommittee has dissolved pending a CCC redefinition of a charge to URC regarding the consumer's perception of treatment. The Patient Care Subcommittee has studied patient care issues described below and various task forces have contributed valuable reports.

STATUS OF URC ACTIVITIES

I. Patient Care Subcommittee

A. Discharges Against Medical Advice

1. Recommended that guidelines be developed to assist clinician in the appropriate use of this category.
   Awaiting Action of Clinical Chiefs' Committee

B. Treatment Plan

1. Recommended that individual treatment plans be recorded for patients in group treatment.
2. Recommended that charts of patients in long term treatment contain continuing documentation of treatment plan and its implementation within 6 months' intervals.
3. Recommended that for those patients whose only treatment is medication, this be clearly stated.
4. Recommended that an ongoing educational program for outpatient services be focused on formulation of treatment plan and its relationship to the course of treatment.
   Tabled by Clinical Chiefs' Committee in favor of considering treatment plan as part of a continuum, from presenting problems through outcome of treatment.

II. Consumer Opinion Subcommittee

A. Conducted pilot study of recently discharged patients. A potential list of 112 patients was reduced to 28. Of these, 9 were interviewed. The interviews were regarded as valuable but disproportionate to the time and effort used in this process. Direct interviews along the lines of the pilot study may be instituted when staff resources are made available.

B. A questionnaire devised to solicit patients' views of their experience at EMHC was submitted to CCC for approval.
Rejected by CCC.

C. Subcommittee requested CCC to redefine the charge to URC relative to consumer opinion and has dissolved as an ongoing subcommittee of URC.

III. Task Force on Norms

Normative length of stay has been defined as the number of days beyond which a case should be subject to review. A stay beyond the norm in no way implies the inappropriateness of the longer stay. A norm for length of stay should *not* be interpreted as defining a maximum length of stay.

A. Norms for extended length of stay recommended and approved by Executive Committee:
- Short General Hospital Psychiatric Unit – 14 days
- Eastern Mental Health Center Inpatient Unit – 30 days

Norms recommended and in final stage of recommendation:
- Research Inpatient Unit
  - –schizophrenic diagnosis group
  - –affective disorders group
- Partial Hospitalization Unit
- Day Hospital Unit

B. Analysis of the efficacy of the 45-day or four interview maximum for the Assessment and Acute Unit instituted 7/1/73 was undertaken through study of computer-stored data, providing initial experience for Program Evaluation Task Force in comparing statistical data with existing policy and providing such feedback to unit chief.

IV. Task Force on Procedures for Review of Extended Length of Care Cases

Focusing on extended length of care for inpatients, URC review is predicated on the expectation that each unit will conduct its own audit and review of each case anticipated to extend beyond the norm.

An Extended Care Review Form will be sent by URC to unit prior to norm date, unless the patient has already been discharged. The URC review will be completed within 7 days beyond the norm date, including in its review a study of the completed form, any additional summary that the unit provides, a review of the chart and if further clarification is needed, discussion with unit chief, team leader, and/or other appropriate clinicians. While it is

within its purview to interview patients, it is anticipated that this will be done only for compelling reasons and after discussion with the unit chief. Finally, the reviewer will note approval or disapproval of the extended length of stay.

It is the intent of EMHC to carry out its review in accordance with existing regulations deriving from legislation of Medicare and other related Federal mandates.

V. URC As A Whole

Legitimizing the work of URC was the approval of a Utilization Review Plan by the Clinical Chiefs' Committee and Executive Committee in the fall of 1973. The structural arrangement, whereby URC functions as a subcommittee of Clinical Chiefs' Committee, appears to be viable. No major structural changes are anticipated.

The Patient Care Subcommittee will be involved in reviews of types of extended care cases, in addition to its ongoing work.

The Consumer Opinion Subcommittee continues to search for an optimal way of learning from consumers how they regard our services, with a regard for the most efficient use of staff time and effort to engage in this activity. A way will need to be found, in order to recognize the importance of translating consumer concerns into priorities and quality of our services.

Spin-offs from URC-raised issues have occurred. For example, Pharmacy Committee's Side Effects/Allergic Reaction Report was stimulated by the URC Study of Adequate Charts. It is hoped that additional spin-offs will occur in the future.

The Norms Task Force, conceived as an ad hoc operation, may be considered to be an ad infinitum exercise, what with our goal of recommending norms for both extended and too brief lengths of stay for outpatient as well as inpatient units. Further, unit norms will be reviewed in light of experience and possibly by selected characteristics, e.g., diagnosis, age, race, etc. Review of indirect services, while of interest to URC, was held in abeyance this year, awaiting the results of the Eastern Mental Health Center's efforts to articulate identifiable aspects of those services that lend themselves to a UR process.

URC provides a review mechanism for the continuing, orderly appraisal of the quality of patient care and use of resources. Its value to EMHC is increasing and may benefit other facilities as we learn increasingly how to look at what we are doing, and in the process, better serve our clients and patients.

CHAPTER NINE

CONCLUSIONS

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CONCLUSIONS

As one moves from region to region, from one type of mental health facility to another, from State to State, differences in practice and in the resources and capabilities available for the performance of quality assurance activities become apparent. Despite this, our intent in this volume has been to present a way of thinking about quality assurance in mental health settings and identify an approach to the technical and nontechnical tasks involved in this endeavor.

We conceive of quality assurance as one part of program evaluation. Quality assurance can enhance clinical programming and the delivery of service to individuals. It can help the organization monitor practice and accumulate data that demonstrate the excellence of institutional programs (or at least show that clinical programs serve those who are supposed to be served, in ways that meet current standards). Quality assurance includes all those activities aimed at assessing or improving the quality of care—utilization review, peer review, certification of staff credentials for practice, promulgation of structural regulations to assure adequate processes of care, and even outcome studies. Utilization review refers to those activities which increase or control the efficiency of the utilization of resources and generally include concurrent and retrospective review. Peer review simply means review activities conducted by discipline peers.

Among the technical tasks identified in this text are the development of criteria and the establishment of administrative structures

and procedures to conduct quality assurance activities. The importance of an adequate record and the implementation of a management information system as basic to the capacity to accomplish this work have been emphasized. The computer may assist in such activities, but more important is the ability to identify relevant questions and design information systems that allow for relatively easy collection and retrieval of such information. Further, since the nature of the criteria determines how adequate care will be defined, the importance of criteria development has been highlighted. Whether one adapts already developed criteria or develops them locally, organizational members must work through and accept the criteria in order to "own" them.

Concurrent review activities are labor-intensive. They may be useful in limiting the use of high-cost services (hospital admission, length of stay, expensive technology) but should not be used routinely to monitor high-volume, short-term services (e.g., admission certification for ambulatory services).

Retrospective review activities include profile analysis and clinical care evaluation studies. The manner in which data for such studies are collected and organized has impact upon the way in which care will be viewed. We emphasize an approach of gradual incrementalism; that is, examining data, thinking about them, asking questions of the data, and then collecting new data and asking somewhat more sophisticated questions. Profiles are summaries of selected information that allow one to identify patterns of care. They permit comparison of individual, unit, or institutional data with other individuals, units, or institutions. Profiles are useful for generating hypotheses and pinpointing clinical care evaluation studies for exploration.

In designing clinical care evaluation studies we advocate simplicity. Generally, one ought to use information that is both easily retrieved and able to provide the best answers to the most significant questions. Thus one needs to be clear about one's hypotheses in the design of these studies.

The nontechnical aspects of quality assurance are at least as important as the technical. Quality assurance demands commitment: first the commitment of administration, and then the involvement and commitment of staff. This commitment is made manifest in the resources available to quality assurance and in the manner in which the results of a quality assurance program are used within an organization and fed back to clinicians and the institution.

The management of a mental health facility uses authority in the service of institutional goals. In this process, management must be technically proficient but must also be aware of group dynamics and

intergroup issues. Groups tend to work best when members feel that work is being accomplished, that status relationships are clear, and that individuals have the opportunity to be heard. We envision management as continuously aware of its multiple goals, allocating and reallocating resources to accomplish its tasks, interactive with its environments, and aware of the needs and values of its subsectors. In a complex organizational matrix, management may tend to become excessively bureaucratized as a way of coping with multiple external and internal strains. Clarity about major goals and values permits an organization to maintain a proactive stance towards its environments and to identify and effectively clarify priorities to promote organizational ends.

The processes of quality assurance can be used to help the organization identify areas in which individual members or organizational subsystems do not conform with established standards. It focuses attention on the educational needs of individuals and of the organization as a whole and points to areas in which the organization is not meeting current goals.

Practitioners must, however, remember that a quality assurance program is intrinsically related to the nature of practice at a particular point in time. To the extent that current images of care are based upon limited knowledge, or even misconceptions, a quality assurance program may be used to reify improper practice. Review practices, criteria, and standards should, therefore, be regularly reevaluated and updated. In the 18th century, adequate psychiatric practice would have involved bleeding and purging patients, spinning patients rapidly in revolving chairs, and alternating hot and cold baths; in later times, patients were subject to extraction of teeth to remove assumed local foci of infections. In the 1950s good care generally implied very lengthy hospitalization. As knowledge accumulates and practice changes, so too must standards and criteria.

Quality assurance programs are costly. Currently, costs average between $6 and $12 per episode of care. Critics of the Professional Standards Review Organization (PSRO) program insist that the costs involved in identifying episodes of inappropriate care are inordinate, while defenders insist that millions of dollars have been saved by limiting the number of hospital days and that simply having a quality assurance program that does concurrent review tends to limit hospital days.

It is not evident that concurrent review is more cost effective than a carefully designed system of retrospective review, but it does seem clear that emphasis on containing costs and assuring professional and institutional accountability will require the continued

expansion of quality assurance programs (Fulchiero et al., 1978; Giglio, Scharfstein, and DeKaye 1976; McNerney 1976; McSherry 1976; Thompson 1978).

There is ongoing national concern with issues of duplication of effort and program. This will undoubtedly lead to quality assurance programs in mental health care that are compatible with such programs in the general health care area.

The development of quality assurance programs will inexorably be tied to issues of reimbursement, and we must also anticipate increasing conflict among discipline groups as to who is a peer, who is competent to engage in which activity, etc. A major task of mental health facilities will be the development (within the framework of State licensing laws) of criteria for assessing the performance of specific clinical tasks and for determining and evaluating clinical competence (evidence of licensure or certification, performance evaluation, recertification, continuing education, etc.). Such activities are appropriately seen as assuring quality. Even more importantly, explicit attention to these issues may help limit intergroup conflict and may promote clarity about tasks.

Finally, it is important to remember that a cookbook is not a chef. Utilization review provides a framework for examining practice and ought not become prescriptive. The value of peer review is that it allows for modification in practice; it may even tolerate innovation and imagination. Quality assurance is with us and will remain with us. Our challenge is to use such programs well, to have them "fit" practice and act to improve care and not to allow them to become straight jackets which constrain us and choke the development of improved care.

REFERENCES

Fulchiero, S.; Miller, S.; Foley, C. R.; Ballantine, H. T.; and Amorosuno, C. C. Can the PSRO's be cost effective? A study of the Commonwealth health agencies monitoring program on the length of stay of Medicaid patients in Massachusetts. *New England Journal of Medicine*, 299:574-580, 1978.

Giglio, J. M.; Scharfstein, H. H.; and DeKaye, A. P. Quality health care: Another administrative nightmare. *Journal of Health Politics, Policy and Law*, 1:18-21, 1976.

McNerney, W. J. The quandry of quality assessment. *New England Journal of Medicine*, 195:1505-1511, 1976.

McSherry, C. K., Quality assurance: The cost of utilization review and the educational value of medical audit in a university hospital. *Surgery*, 80:122-129, 1976.

Thompson, R. E. Evaluating quality isn't worth the cost . . . unless. *The Hospital Medical Staff*, 7(11):1-4, 1978.

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AN ANNOTATED BIBLIOGRAPHY

References listed in the following section have been selected from over 250 references identified in two Department of Health and Human Services publications. Quality Assurance for Alcohol, Drug Abuse, and Mental Health Services: An Annotated Bibliography *(DHEW Publication # 79-796), compiled by O. B. Towery, Gordon R. Seidenberg, and Vittorio Santoro, covers the relevant literature through 1977.* Quality Assurance for Alcohol, Drug Abuse, and Mental Health Services: An Annotated Bibliography of Recent Literature *(HCFA Publication # 80-30035), by Tamar Joy Kahn and Sophie S. Berger under the direction of Gordon R. Seidenberg, reflects the literature from 1977 through the first quarter of 1980.*

American Psychiatric Association. Model law on confidentiality of health and social service records. *American Journal of Psychiatry,* 131(1): 138-144, January 1979.

The APA Task Force on Confidentiality of Children's and Adolescents' Clinical Records and the APA Committee on Confidentiality prepared this document, which was then approved by the APA's Board of Trustees and Assembly Executive Committee. It is intended to serve as a prototype for State legislation. Sections 15-18 provide for protecting patient confidentiality when data is disclosed to insurance companies, State or local information systems, or federally funded programs. The same journal issue includes an editorial (by J. S. Beigler, pp. 71-73) and a commentary (by S. Nye, pp. 145-147) on the model law.

American Psychiatric Association. Peer Review Committee, *Manual of Psychiatric Peer Review.* Washington, D.C.: The Association, 1976.

This three-part manual was produced through a collaborative effort of the APA, the American Psychoanalytic Association, and the American Academy of Child Psychiatry. Part One discusses general, administrative, and legal aspects of psychiatric peer review and provides model screening criteria for inpatient and outpatient treatment of specific psychiatric disorders. Part Two discusses psychoanalytic peer review and includes model criteria sets for psychoanalysis. Part Three deals with child psychiatry; model screening criteria are presented for intermediate care, for acute care, and for partial hospitalization and outpatient treatment of psychiatric disorders in children and adolescents.

American Psychological Association/CHAMPUS National Advisory Panel and Staff Members, R. J. Bent, et al. *A System of Peer Review for Outpatient Psychological Services.* Washington, D.C.: American Psychological Association, October 1979.

Eight members of the National Advisory Panel and staff of the American Psychological Association/CHAMPUS peer review project prepared this document to serve as a model of an ambulatory review system which can be utilized in the context of a third-party benefits program. It is meant to be of assistance to psychologists who provide care to insurance beneficiaries or who wish to set up their own review system in an organized care or group practice setting. It includes a set of criteria for outpatient psychological services similar to those developed for use in the APA/CHAMPUS Review System.

Apostoles, F. E.; Little, M. E.; and Murphy, H. D. Developing a psychiatric nursing audit. *Journal of Psychiatric Nursing and Mental Health Services,* 15(5):9-15, May 1977.

Three nurses describe in detail the development of an initial, primarily process-oriented, nursing audit in one clinical division of a large psychiatric hospital. They also present psychiatric nursing criteria based on outcome measures for a retrospective audit of suicidal behavior.

Bartlett, D. P.; and Intagliata, J. Integration of quality assurance and program evaluation activities in alcoholism treatment programs: Part II. *Quality Review Bulletin,* 6(1):17-22, January 1980.

Integration of quality assurance and program evaluation activities in alcoholism treatment programs can enhance the effec-

tiveness and efficiency of these activities and encourage greater staff support. In this article, second of a two-part series, the authors suggest organizational changes meant to facilitate implementation of an integrated evaluation system and present a model for involving staff extensively in all phases of system design.

Berkman, B.; and Clark, E. Survey offers guidelines for social work. *Hospitals*, 54(6):105-106,110,112, March 16, 1980.

An ad hoc committee of the Massachusetts Chapter of the Society of Hospital Social Workers conducted a survey of social work practice in 40 acute care hospitals. The purpose of the New England Regional Survey of Social Work Practice was to develop baseline data upon which practice standards could be based. The survey instrument elicited normative profile information on patient social indicators, medical conditions, social work intervention patterns, problems dealt with, and outcomes of intervention. This questionnaire could now be used as a guide for medical record documentation or for review of psychosocial care.

Brook, R. H.; Kamberg, C. J.; and Lohr, K. N. *Quality Assessment in Mental Health*, Rand Note N-1206-HEW. Santa Monica, Calif.: Rand, September 1979.

The authors examine quality assessment in reference to mental health care and the psychosocial aspects of medical care. They discuss special issues involved in choosing problems for study, identifying applicable and feasible methods, and collecting reliable and valid data. They note that mental health professionals have a unique contribution to make, both by investigating mental health care quality and by collaborating with other health professionals in studies of care for nursing home patients.

Chien, C.; Solomon, K.; and Platek, T. E. Macro-monitoring: A step toward rational psychopharmacotherapy. *American Journal of Hospital Pharmacy*, 35(4):397-402, April 1978.

A checklist was used to monitor the extent of irrational drug use in five different clinical settings: a psychiatric inpatient unit of a general hospital, a day treatment center of a general hospital, two aftercare units of a state hospital, and a nursing home regularly visited by psychogeriatric consultants. A considerable amount of inappropriate drug use was found. For those psychiatric facilities that cannot afford a psychopharmacologist consultant, the checklist described here can be a useful tool for monitoring prescribing practices.

Claiborn, W. L.; and Stricker, G. Professional standards review organizations, peer review, and CHAMPUS. *Professional Psychology,* 10(4):631-639, August 1979.

The PSRO review system has had a major impact on patterns of general hospital care and will probably have a similarly large effect on ambulatory care in the future. However, it is not clear that medically oriented PSRO review will be appropriate for psychological services. The Civilian Health and Medical Program of the Uniformed Services has contracted with both the American Psychological Association and the American Psychiatric Association to develop review systems for their respective professions. The approaches of the two organizations differ in several important respects. The American Psychological Association's CHAMPUS peer review experiment could well provide the model for an ambulatory review system in mental health.

Coulton, C. J. *Social Work Quality Assurance Programs: A Comparative Analysis.* Washington, D.C.: National Association of Social Workers, 1979.

This monograph reports the findings of a 2-year study of hospital social work quality assurance programs that was sponsored by the NASW Health Quality Standards Committee. The 27 quality assurance programs identified are analyzed and compared. The most comprehensive programs consisted of 3 interrelated components: patient information systems, peer review systems, and guaranteed access systems. Recommendations are made in the areas of minimum program components, relationship to PSRO, and professional issues to be addressed.

Donabedian, A. Quality of medical are: A concept in search of a definition. *Journal of Family Medicine,* 9(2):227-284, August 1979.

Patient care consists of technical and interpersonal components: "quality" of technical management depends on the balance of its expected benefits and risks; "quality" of the interpersonal process consists in conformity to legitimate patient expectations and to social and professional norms. The author hypothesizes a unifying model, which embraces both personal risks/benefits and social costs/benefits. Admittedly, such a multifaceted definition of quality makes it difficult to formulate generalizable criteria and standards. Professional schools will have to discover and teach strategies of care that yield the highest net utility for the entire population.

Goran, M. J. The evolution of the PSRO hospital review system. *Medical Care,* 17(5 Suppl.): 1-47, May 1979.

The author examines the history of the PSRO program and its current status. The program's priority goal at present is to reduce the excessive use of hospital care and services throughout the country. The author believes that elimination of much of the variation in hospital practice patterns would benefit the quality of patient care as well as help to contain costs. He describes the current state of the art of hospital review, including such advances as problem-oriented review, the incorporation of cost-effectiveness analysis into the review system, and more sophisticated profile analysis.

Grant, R. L. Problem-oriented system and record keeping in the behavioral therapies. *Journal of Community Psychology,* 7(1):53-59, January 1979.

A major outcome of the disappointment in the adequacy of health care records has been the development and increasing adoption of Weed's Problem-Oriented Record System. This article summarizes Weed's approach and proposes that its guidelines and advantages are suited for incorporation into behavioral therapy training. The expected result of such training should be records more amenable to audit or review for such purposes as third-party payment, supervision, and peer review.

Greenstein, M. Quality assurance and program evaluation: Interactions between diverse approaches to quality of care. *Journal of Quality Assurance,* 2(2):8-11, Spring 1980.

The Manhattan Psychiatric Center's review system incorporates both patient-centered quality assurance activities and broad-based program evaluation studies that cut across clinical units and administrative departments. The interaction between the two review components has improved communication, increased review staff visibility and involvement in hospital affairs, and enlarged the numbers and types of monitoring approaches available. An operational diagram showing the relationship between quality assurance and program evaluation components is provided.

Hastings, G. E.; Sonnerborn, R.; Lee, G. H.; Vick, L.; and Sasmor, L. Peer review checklist: Reproducibility and validity of a method for evaluating the quality of ambulatory care. *American Journal of Public Health,* 70(3):222-227, March 1980.

The authors describe the construction and evaluation of a 35-item checklist used in performing peer review of ambulatory medical

records for a jail health program. Scores obtained by using the checklist were carefully evaluated for reproducibility. Both intra-reviewer judgments were found to be highly consistent. Peer Review Checklist scores also correlated positively with scores obtained by using a series of specific protocols with explicit criteria.

Health Standards and Quality Bureau and National Institute of Mental Health. *Planning for Discharge and Follow-up Services for Mentally Ill Patients.* A. B. Brands, ed. DHEW Publication No. (ADM) 78-673, Rockville, Md.: Superintendent of Documents, U.S. Government Printing Office. Washington, D.C., 1979.

The Medicare and Medicaid special conditions of participation for psychiatric hospitals require that all patient records include a discharge summary. This publication, which was composed by a workgroup of NIMH staff and consultants who participate in surveying psychiatric hospitals for Medicare certification, describes the philosophy and processes involved in developing, carrying out, and documenting individualized discharge planning and follow-up services. It is intended to assist surveyors and hospital staffs in demonstrating improvements in these areas of treatment.

InterQual. *Intensification Criteria for Concurrent Utilization Review.* Chicago: InterQual, August 1978, 44 pp.

This manual describes a special approach to concurrent utilization review based on the use of "intensification" criteria that address the appropriateness of short-term hospitalization in terms of the severity of illness and the intensity of services provided. It includes a brief set of psychiatric criteria.

Joint Commission on Accreditation of Hospitals. *Consolidated Standards for Child, Adolescent, and Adult Psychiatric, Alcoholism, and Drug Abuse Programs.* Chicago: The Commission, 1979.

As part of a current effort to streamline its survey and accreditation process, the JCAH has integrated its standards for all types of psychiatric, alcoholism, and drug abuse programs (with the exception of community mental health services) into this single compilation. The standards are listed under four categories: program management, patient management, patient services, and facilities management.

Joint Commission on Accreditation of Hospitals. *Principles for Accreditation of Community Mental Health Service Programs.* Chicago: The Commission, 1979 revision.

This revision of the 1976 accreditation manual reflects the new JCAH "Balanced Service System" conceptual model. It is divided into two sections: a description of the model on which the accreditation principles (formerly called standards) are based; and a quality assurance section which displays each of the principles, subprinciples, and performance indicators used. A companion "Program Review Document for Community Mental Health Service Programs" provides the questionnaires and forms used by JCAH surveyors.

Kass, F.; Charles, E.; and Buckley, P. Two-year follow-up of a peer review training program for residents. *American Journal of Psychiatry,* 137(2):244-245, February 1980.

This article briefly describes a participatory peer review training program for psychiatric residents in an outpatient setting. A special problem-oriented peer review form was devised for the program, which involved third-year resident review of the cases of their second-year colleagues. Follow-up contact showed that, while both training program participants and nonparticipants believe that peer review has a positive effect on patient care and on the educational process, a striking 80 percent of the participants—as opposed to none of the nonparticipants—are currently participating in some form of peer review.

Levine, M. S.; Weiner, O. D.; and Carone, P. F. Monitoring inpatient length of stay in a community mental health center. *Journal of Nervous and Mental Disease,* 166(9):655-660, September 1978.

The authors assess their experience with reviewing the length of stay in the Connecticut Mental Health Center's inpatient units in 1974-75. The study helped to refine the review process and led to recommendations on selection of cases for review based on their educational value. Analysis of cases which exceeded length-of-stay norms suggested that these norms should reflect specific treatment protocols related to diagnosis rather than diagnosis alone.

Liptzin, B. A Federal view of mental health program evaluation. *Professional Psychology,* 8(4):543-552, November 1977.

Current thinking at the National Institute of Mental Health on what evaluation is, whom it is directed to, how it can be used, and what other activities relate to it, is discussed. Other topics ad-

dressed include the program evaluation and quality assurance implications of the Community Mental Health Centers Amendments of 1975 and the relationship of quality assurance activities to private office practice.

Longabaugh, R.; Fowler, D. R.; Hostetler, M.; McMahon, M.; and Sullivan, C. Focus on patient problems: Use of the problem-oriented record in a proposed evaluation study of social isolation. *Quality Review Bulletin,* 4(4):4-7, April 1978.

The authors believe that problem-oriented evaluation studies have advantages over diagnostically oriented audits of psychiatric topics. They can be adapted to evaluation of interdisciplinary patient care and can focus attention on critical behavioral problems. Problem-oriented records enable all staff members to record their observations on a single form. This article discusses a study to assess the care of socially isolated or withdrawn patients in an acute care psychiatric facility. The screening elements are listed and explained.

Luft, L. L.; and Newman, D. E. Therapists' acceptance of peer review in a community mental health center. *Hospital & Community Psychiatry,* 28(12):889-894, December 1977.

The 80-therapist attending staff of a CMHC was interviewed to determine attitudes toward the center's interdisciplinary peer review system. Although many reservations were expressed, the system was generally considered to maintain an appropriate balance between quality of care and cost control considerations. More than 90 percent of the therapists said they found peer review to be an educational experience. The authors believe this surprisingly positive response can be attributed to design of the system by and for practitioners and to careful selection and adequate remuneration of reviewers.

Luft, L. L.; Smith, K; and Kace, M. Therapists', patients', and inpatient staff's views of treatment modes and outcomes. *Hospital & Community Psychiatry,* 29(8):505-511, August 1978.

This article explores the correlation between the perceptions of patients, therapists, and staff concerning inpatient treatment in a community mental health center. Data on 199 consecutive admissions showed little agreement on the identification of patients' symptoms or on assessments of change. There was also little agreement between therapists and staff in reporting the major treatment modalities used or in identifying cases of poor therapists/staff com-

munication. However, neither the use of different treatment approaches nor the existence of communication problems was related to longer lengths of stay or poorer outcomes.

Maguire, L. Peer review in community mental health. *Community Mental Health Journal*, 14(3):190-198, Fall 1978.

The author discusses the medical origins of review legislation and how peer review can be adapted to the unique needs of community mental health centers. He suggests three appropriate models in review: a problem model, a sequential model using checkpoints in patient flow, and Yale's Psychiatric Utilization Review and Evaluation Project (PURE) model. All three depend upon review of records by a committee of respected clinical staff representing a range of professions.

Mansfield, M. The occupation of therapists: Roles of psychiatric occupational therapists and preparation of generic audit criteria. *Quality Review Bulletin*, 4(4):8-12, April 1978.

In preparation for a multidisciplinary psychiatry department audit in their hospital, occupational therapists developed generic screening elements to assess care provided by members of their own profession. This article describes the treatment and documentation responsibilities of the psychiatric occupational therapists and the criteria they developed.

McAninch, M., and Weedman, R. D. The purpose and content of psychiatric records in accreditation procedures. *National Association of Private Psychiatric Hospitals Journal*, 10(3):35-39, Spring 1979.

The psychiatric patient record serves as a basic source of information for a variety of quality assurance functions. The director and deputy director of the JCAH Accreditation Program for Psychiatric Facilities present guidelines on the type of information that must be documented. This includes identification data and the presenting problem, assessment information, treatment plans, and follow-up and aftercare recommendations.

McAuliffe, W. E. Measuring the quality of medical care: Process versus outcome. *Milbank Memorial Fund Quarterly*, 57(1):118-152, Winter 1979.

The desirability of process versus outcome measures of quality is an unsettled issue among experts on quality assurance. The primary argument for the outcome approach is that, since the goal of the

medical care is health, one should concentrate on measuring the achievement of health. However, analysis shows that there are parallel sets of problems—involving adequacy, validity, and practical problems of data collection and quality—in the use of both outcome and process measures. The author believes that there is insufficient evidence as yet for making a clear choice between the two approaches.

Mitchell, N. L. A suggested schema for utilization review for a community mental health center. *Journal of the National Medical Association,* 69(4):237-239, April 1977.

The author describes the efforts of an interdisciplinary committee to establish a utilization review process for an outpatient mental health center. Three record-keeping models were examined: the model criteria problem-oriented set, the problem-oriented record, and a combination diagnosis and standardized problem list. After selecting a combination record format, the committee developed a 5-phase utilization review procedure.

National Institute of Mental Health. *Psychotropic Drugs: Approaches to Psychopharmacologic Drug Use,* Towery, O. B. and Brands, A.B., eds. DHEW Publication No. (ADM) 79-758. Rockville, Md.: Superintendent of Documents, U.S. Government Printing Office, 1979.

This two-part document was composed to assist community mental health centers in instituting drug use review programs as part of a comprehensive quality assurance system. Part I is a guide for drug use review in mental health facilities, written by M. H. Stolar of the American Society of Hospital Pharmacists with the guidance of a multidisciplinary group of pharmacists, pharmacologists, psychiatrists, social workers, and registered nurses. Part II is a set of psychopharmacologic screening criteria that was developed by a task force of the Peer Review Committee of the American Psychiatric Association.

National Institute of Mental Health. *National Standards for Community Mental Health Centers: A Report to Congress.* Rockville, Md. NIMH, January 1977.

This report was submitted to Congress by the Secretary of Health, Education, and Welfare as required by the Community Mental Health Centers Amendments of 1975. It begins with a brief history of medical standards setting in this country, with special attention to the concerns of mental health care. The second section proposes a set of care standards and associated criteria for assess-

ing the quality of clinical services in CMHCs. The final section identifies a number of potential uses that could be made of the proposed standards.

Nelson, R. H. Program evaluation/quality assurance: A waste of time? *Journal of Community Psychology,* 7(4):368-370, 1979.

The author asserts that mental health program evaluation has failed to become a practical tool and that, given the lack of sufficient data to support the development of diagnosis-specific criteria sets relating to specific psychological treatment approaches, quality assurance is likely to meet the same fate. Individualized treatment planning offers a more promising route to meaningful accountability.

Pilat, J. M. Consideration in evaluation of hospital social work services for alcoholic patients. *Quality Review Bulletin,* 5(11):20-23, November 1979.

The author discusses the many functions a social worker can undertake in the treatment of alcoholic patients in hospital settings, including roles in the psychosocial evaluation, acute-phase treatment and discharge planning, and aftercare stages. She suggests some general considerations relevant to evaluating the quality of such social work services.

Prien, R. F.; Balter, M. B.; and Caffey, E. M. Hospital surveys of prescribing practices with psychotherapeutic drugs. *Archives of General Psychiatry,* 35(10):1271-1275, October 1978.

Surveys of hospital psychotherapeutic drug use tend to be critical of prescribing practices while failing to provide adequate information for evaluating the appropriateness of these practices. Three recent multi-hospital surveys of psychotherapeutic drug use are examined in detail to illustrate their limitations. It is concluded that more intensive studies should be undertaken which focus on long-term treatment strategies and reasons for treatment for carefully selected, well-defined populations. Such surveys would aid in establishing more relevant drug use guidelines and drug utilization review systems.

Sarnat, J. E.; Whitaker, L. C.; and Arnstein, R. L. Psychotherapy quality assessment. *Journal of American College Health.* 28(3):131-139, December 1979.

This 3-part paper discusses the need for, conduct of, and problems involved in assessing the quality of brief psychotherapy in college

mental health services. In part one, Whitaker examines the practical and heuristic reasons for developing a systematic quality assessment method. Sarnat then describes one in a series of quality assessment efforts at the Mental Health Division of the University of Massachusetts Health Services, focusing on the development and use of a new method of record-keeping and patient records review. In part three, Arnstein discusses difficulties the Yale mental hygiene clinic has encountered with quality assessment and adds a note of caution about the feasibility and wisdom of embarking on a program of quality assessment of psychotherapy.

Scrivens, J. J., Jr.; Weber, C., Jr.; Sather, M.; and Geck, W. Filling and refilling practices with diazepam and methyldopa. *Hospital Formulary,* 14(9):830-838, September 1979.

A review of the literature reveals that medication misuse, predominantly overprescribing, is a widespread problem in health care institutions. A study was performed at the Tampa Veterans Administration Medical Center to explore the factors contributing to excessive use of the drugs diazepam and methyldopa and to assess the impact of pharmacist and Pharmacy and Therapeutics Committee intervention on misuse of these medications. Prescription use data for the two drugs were reviewed retrospectively for a 6-month period. Diazepam usage was then monitored prospectively for 3 months. The retrospective study demonstrated that many patients had received drugs by early refills and/or duplicated prescriptions. The prospective monitoring program led to substantial reductions in the amount of diazepam purchased.

Seidenberg, G. R.; and Johnson, F. S. A case study in defining developmental costs for quality assurance in mental health center programs. *Evaluation and Program Planning,* 2(2):143-153, 1979.

Despite external demands, community mental health centers have been slow to implement quality assurance programs, to a large extent because of concerns about the price tag and cost-effectiveness of such programs. Drawing upon the experiences of an NIMH-supported special project in North Carolina, this paper reports specific information from three mental health center programs on the start-up costs and staffing of quality assurance activities. The report is predicated on the assumption that a quality assurance program should be implemented in building block fashion so as not to become a burden on the CMHC's direct service delivery system.

Sharfstein, S. S.; Towery, O. B.; and Milowe, I. D. Accuracy of diagnostic information submitted to an insurance company. ***American Journal of Psychiatry,*** **137(1):70-73, January 1980.**

The Washington Psychiatric Society asked its members for anonymous diagnoses for patients they had seen in 1977 under the Blue Cross/Blue Shield Federal Employees Program. These diagnoses differed markedly from those found by a federally funded Mental and Nervous Disorder Utilization and Cost Survey to have been submitted in claims for the same patient population. The authors reason that inaccurate information was submitted primarily because of concern about patient confidentiality. They urge that special claims and peer review procedures be developed to assure confidentiality and describe such an attempt by the Washington Psychiatric Society and Blue Cross/Blue Shield.

Sheehy, M.; and Charles, E. Evaluation of problem oriented treatment planning in outpatient psychotherapy. ***Journal of Clinical Psychiatry,*** **39(7):614-619, July 1978.**

This article presents a systematic evaluation of a modified problem-oriented medical record approach applied to psychotherapy care in an outpatient psychiatric clinic. As compared with the 4-year period preceding institution of problem-oriented treatment planning, there was a 50-percent reduction in patient drop-out with no change in clinician-rated outcomes. Contrary to the authors' expectations, staff acceptance of the approach was good. The treatment plan format is included.

Siegel, C.; Laska, E.; Griffis, A.; and Wanderling, J. Quantitative care norms for a psychiatric ambulatory population in a county medical assistance program. ***American Journal of Public Health,*** **68(4):352-358, April 1978.**

The authors present a method for developing and applying quantitative care norms to acute psychiatric outpatients. Norms were generated which relate both to monthly quantity of services rendered and to length of active treatment period. Data are presented on the application of these norms in Medicaid review, and significant findings of variation are explored. The methodology used is generalizable to applications ranging from planning to utilization review.

Silver, L. F. Child psychiatry perspectives: Accountability and the future of child psychiatry. *Journal of the American Academy of Child Psychiatry,* 18(1):176-185, Winter 1979.

The author reviews the increasing governmental demand for accountability in medicine and its effect on the practice of child psychiatry. He discusses the impact of peer and utilization review and the concept of competency and licensure, child psychiatric education, and the effect of accountability demands on the "mental health of child psychiatrists." He believes that formal accountability has a positive influence on the field and that child psychiatrists should be actively involved in setting standards.

Stelmachers, Z. T.; Baxter, J. W.; and Ellenson, G. M. Auditing the quality of care of a crisis center. *Suicide and Life-Threatening Behavior,* 8(1):18-31, Spring 1978.

This article defines different types of audits, lists checkpoints in patient flow in a mental facility which lend themselves to review, and describes an audit at a hospital-based crisis intervention center. The audit was designed to determine the quality of medical-psychiatric consultation and to develop criteria for its initiation. Corrective actions that resulted included a change in the form for recording clinical information, selection of certain activities for continuous monitoring, and development of guidelines for dealing with requests for frequently abused medications and criteria (list included) for requesting medical-psychiatric consultation.

Sullivan, F. W. Peer review and professional ethics. *American Journal of Psychiatry,* 134(2):186-188, February 1977.

The public has not been kept adequately informed on the nature and extent of peer review. The author suggests ethical guidelines for physicians and committees participating in peer review and recommends that review of professional ethics be incorporated into the review of the quality, cost, quantity, and availability of medical services.

Towery, O. B.; and Windle, C. Quality assurance for community mental health centers: Impact of P.L. 94-63. *Hospital & Community Psychiatry,* 29(5): 316-319, May 1978.

The Community Mental Health Centers Amendments of 1975 mandated three types of quality assurance activities: the development of national standards for CMHCs, the establishment within each CMHC of a utilization/peer review program, and creation of a

system of program evaluation. The authors describe the CMHC standards subsequently developed by the National Institute of Mental Health, including their relationship to the accreditation standards of the JCAH and their potential uses. They also discuss the need to establish CMHC quality assurance programs that will interface with the PSRO program and the kinds of program evaluation activities centers are expected to conduct.

Vanagunas, A. Quality assessment: Alternate approaches. *Quality Review Bulletin*, 5(2):7-10, February 1979.

This article summarizes 11 different approaches to quality assessment: the use of "tracer" health problems to evaluate overall care; health accounting based on evaluation of the level of outcome to be expected with optimal quality care; the outcome-based "staging" approach applicable to ambulatory care; the "bi-cycle" model that combines auditing and continuing medical education; the Quality Assurance Monitor system developed by the Commission of Professional and Hospital Activities; the comprehensive quality assurance system developed for Kaiser Permanente medical centers; the California Medical Association/California Hospital Association Educational Patient Care Audit system; the Performance Evaluation Procedure developed by the Joint Commission on Accreditation of Hospitals; concurrent quality assurance; the California Medical Insurance Feasibility Study plan; and the criteria mapping approach to tracking the physician decision-making process.

Van Korff, M. R.; and Kramer, M. *Mental and Nervous Disorders Utilization and Cost Survey*. National Institute of Mental Health and U.S. Office of Personnel Management, May 1979.

The Civil Service Commission and the National Institute of Mental Health funded a survey of the utilization of outpatient mental health services during 1977 by enrollees in the Blue Cross and Blue Shield Federal Employees Program in the Washington, D.C. area. This report describes and analyzes the data that were collected. A preliminary attempt is made to use these data to assess the potential cost effectiveness of peer review as a utilization control mechanism.

Weiner, O. D.; Carone, P. F.; Zil, J. S.; Urbin, M. A.; and Ginath, Y. Justifying inpatient admissions at a community mental health center. *Journal of Nervous and Mental Disease*, 166(3):153-164, March 1978.

The authors present a model for screening and reviewing CMHC inpatient admissions. The model involves use of both a diagnostic

criteria set and a functional criteria scale. In a 1976 field test at the Connecticut Mental Health Center, it was found that the diagnostic criteria set could be applied in three-fourths of the cases and the scale of function in all cases. The test also demonstrated that 90 percent of the admissions could be screened adequately by nonphysicians. The mean time to process a case was about 58.4 minutes per admission, with an average direct cost per case of $6.68.

West Australian Peer Review Sub-Committee. Peer review—The West Australian experience. *Australian and New Zealand Journal of Psychiatry,* 13:353-356, December 1979.

A pilot study of psychiatric peer review was conducted by a local branch of the Royal Australian and New Zealand College of Psychiatrists. Participants were divided into three sub-groups, which devised their own systems of assessment and data collection. Subsequent discussion led to development of a workable system that employs a "rolling," or ongoing, technique in which a group of four psychiatrists form the peer review group. Following each assessment a new member joins the team, and the longest serving person is assessed before leaving. The difficulties of peer review are discussed, and the importance of the link between peer review and continuing psychiatric education is stressed.

West, J. W. A medical audit of acute alcoholism and chronic alcoholism. *Alcoholism: Clinical and Experimental Research,* 2(3):287-291, July 1978.

The author lists the essential characteristics of an acceptable medical audit and describes two alcoholism audits in detail. The audit for acute alcoholism was conducted in a large private general hospital where patients are treated on the general medical service; the one for chronic alcoholism involved an alcoholism rehabilitation unit in a large general hospital in a teaching center. The audit criteria and summaries are included.

Winialski, N. Multidisciplinary alcoholism audit covers acute, O.P. care. *Hospital Peer Review,* 3(10):135-137, October 1978.

A multidisciplinary audit of a community hospital's alcoholism unit is described. Both inpatient and outpatient services were examined. Criteria were developed and analyses performed by members of all professions involved. Audit objectives were to investigate the reasons for admission and treatment, to establish standards of care, and to evaluate the continuity of care. The audit criteria are listed.

Withersty, D. J.; and Spradlin, W. W. A system to document medical records for utilization review. *Hospital & Community Psychiatry,* 28(12):881,885, December 1977.

The authors describe the patient progress review sheets used by West Virginia University's Department of Behavioral Medicine and Psychiatry Inpatient Service for documentation purposes. The system was designed for the utilization review process but has also been a valuable aid to medical audits.

Woy, J. R. Quality assurance. In: *Evaluation in Practice: A Sourcebook of Evaluation Studies from Mental Health Care Systems in the United States,* Landsberg, G.; Neigher, W. D.; Hammer, R. J.; Windle, C.; and Woy, J. R., DHEW Publication No. (ADM) 78-763. Rockville, Md.: 1979.

The quality assurance section of this NIMH sourcebook on program evaluation consists of an overview by Woy and six summaries of individual concurrent review or patient care evaluation projects: "The experiences of the quality assurance program in the Connecticut Mental Health Center" by J. Henisz; "Application of utilization review procedures in the community mental health center" by W. E. Block; "Quality assurance and the Columbia Medical Plan" by J. Hankin; "Peer review of prescribing patterns in a CMHC" by H. Diamond, R. Tislow, T. Snyder, and K. Rickers; "The significance of a significant other: how one audit committee chooses to evaluate the effectiveness of discharge planning" by R. Longabaugh; and "Clinical conferences for synergizing quality assurance activities" by A. Richman. Some pertinent references are included in the bibliography at the end of the book.

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